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Processing Trauma

Studies into

**Posttraumatic Stress Disorder, Eye Movement
Desensitisation and Reprocessing and Posttraumatic
Growth**

by

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Thesis submitted in partial fulfilment of the requirements for the degree of Doctor
of Clinical Psychology

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Declaration

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Summary

Trying to understand trauma and how such experiences impact upon the individual has generated much interest in both academic and clinical domains. Knowing how best to treat individuals who have experienced trauma has been the focus of much research particularly in relation to the emergence, maintenance and treatment of PTSD. While PTSD results in various symptomatology, key characteristics concern a sense of being “stuck” on the trauma which keeps the person reliving it through thoughts, feelings and images and a need to avoid anything which reminds them of the trauma. Such avoidance is suggested to prevent the opportunity for processing and integrating the distressing material. One key clinical question is how to help the person work through their trauma without them becoming overwhelmed by trauma symptoms? Eye Movement Desensitisation and Reprocessing (EMDR) is a relatively new technique that has been reported to help PTSD sufferers reduce the intensity and intrusiveness of traumatic thoughts and images. Despite the growing clinical evidence of the effectiveness of EMDR, a strong debate exists within the research literature regarding its empirical and theoretical validity. One aspect of this dissertation is an experimental study looking at the role of eye movements in Eye Movement Desensitisation and Reprocessing and testing a working memory model of “distress reduction”. Of course not everyone who experiences a traumatic event will go on to develop PTSD. An often neglected area of trauma investigation is how some individuals experience positive change and personal growth as a result of their traumatic experiences. This is an area that is now beginning to receive some attention and has been termed Posttraumatic Growth (PTG). The move away from looking exclusively at the impact of trauma to consider how people who have experienced trauma might construct a more positive understanding of themselves in the light of the trauma forms the main section of this dissertation. This exploratory study uses personal experience narratives of posttraumatic growth.

Preface

The integration and processing of traumatic memories is an essential process by which individuals come to gain mastery over their distress and make the unpredictable and meaningless meaningful. The central theme of this thesis concerns the integration and processing of traumatic memories and as such chapter I begins with a review of the literature on posttraumatic stress disorder and posttraumatic growth. In exploring the broader picture of what it might mean to experience trauma, I have focused not only on the negative impact of traumatic experiences, but also to look at the positive impact that trauma can bring. My aim is to provide a more salutogenic perspective to the trauma literature by focusing on people's strengths and the ways that they have coped and adjusted to trauma. However, I am very aware that many individuals who have experienced a traumatic event, can be left with overwhelming feelings of distress which can make coping with everyday life very difficult. In order to find appropriate ways to assist people to begin processing their traumatic experiences, a relatively new treatment has been developed, Eye Movement Desensitisation and Reprocessing (EMDR), which is based upon helping individuals process their traumatic memories.

Chapter II focuses on the role of eye movements in EMDR and the testing of a working memory model of 'distress reduction'. One potential advantage of EMDR is that it may provide the means whereby individuals can begin to integrate and process their traumatic memories without becoming overwhelmed by them. While there is a growing body of research supporting the efficacy of EMDR it is also a treatment that has attracted much debate. In particular whether there is anything therapeutically unique about eye movements. The question of how as clinicians should we best help clients bring about positive change is further explored within Chapter III. This chapter looks at positive change processes within personal experience narratives of self-perceived trauma. Here greater attention is given to the therapeutic and posttraumatic growth literature. In contrast to the experimental design of Chapter II, Chapter III draws upon written narratives in the form of people's stories about their traumatic experiences and their experiences of positive change and personal growth.

Chapter IV reviews the research process and highlights some of the methodological, ethical and practical issues related to the research. This chapter also focuses upon the potential benefits of the research process both for the researched and myself, as the researcher. Given the salutogenic focus of this thesis emphasis is once again given to exploring areas such as the therapeutic use of story telling and vicarious posttraumatic growth.

Chapter I

Processing Trauma: A Review of the Literature on Posttraumatic Stress Disorder and Posttraumatic Growth

ABSTRACT. *This review focuses upon the processing of traumatic experiences by exploring the literature on Posttraumatic Stress and Post-traumatic Growth. This paper challenges the perception that the experience of trauma brings with it exclusively negative consequences for the individual. It is suggested that significant positive and beneficial experiences may co-exist with the more accepted negative responses to the trauma. This paper adopts a salutogenic perspective and will review research on (a) factors contributing to positive outcome, (b) positive responses to trauma, including positive changes and personal growth, changes in the perception of self, changes in relationships with others, and changes in individual's philosophy of life resulting from their traumatic experiences, and (c) treatments for processing and integrating traumatic memories. It is suggested that positive responses to trauma and issues of posttraumatic growth emerge from an existential search for meaning in the aftermath of trauma and stress the importance of processing and integrating trauma experiences. It is argued that posttraumatic growth has not yet fully acquired legitimacy, thus professionals may fail to hypothesise that such adaptive and positive responses may become a feature of the clients experiences in the aftermath of trauma. Clinical implications in relation to the creation of the conditions that facilitate posttraumatic growth are considered.*

Traumatic experiences are common. It has been estimated that potentially traumatic events affect somewhere between 40 to 70 per cent of the population (Breslau, Davis, Andreski and Peterson, 1991; Norris, 1992). Of course traumatic experiences take many different forms and will affect individuals differently. Traumatic experiences can range from out of the ordinary events such as natural disasters to more common experiences such as the death of a loved one. While many of us are likely to experience a traumatic event or at the very least a highly stressful life event, only a relatively small percentage will go on to develop Posttraumatic Stress Disorder (PTSD). Despite difficulties in calculating prevalence rates for PTSD, various studies have demonstrated a lifetime prevalence of between 5% and 15% for current levels, and 4% to 12% for lifetime diagnosis (Yule, Williams and Joseph, 1999). Other studies have found prevalence rates of PTSD in 1.3% (Helzer, Robins and McEvoy, 1987) and 9% (Breslau et al, 1991) of the general population, and at least 15% in psychiatric

inpatients (Saxe, van der Kolk, Hall et al, 1993). As is common when considering prevalence rates there is often a discrepancy between estimates quoted due largely to differences in assessment methodology.

It has been recognised that one of the key factors affecting our reactions to potentially traumatic situations concerns our appraisal of the situation (Joseph, 1999). In looking at the impact of trauma, this paper will review two distinct areas of research: The more established literature on PTSD and the relatively new and growing literature on Posttraumatic Growth. The aim of this review is to explore the available literature on trauma, with particular emphasis on the processing of traumatic experiences and how this knowledge can help us clinically in our work with those who have experienced traumatic events. Given that this review emphasises the processing of trauma, the literature explored draws mostly from cognitive theories of information processing and emotional processing and is situated within a psychosocial perspective.

PTSD: a brief introduction

PTSD (APA, 1994) has generated much research since the term was first defined just over twenty years ago. PTSD can apply to any traumatic event where the person appraises an event as constituting an overwhelming threat. An actual definition of what constitutes a traumatic event has been difficult to render precisely (Joseph, Williams and Yule, 1997). However the DSM-IV criteria for PTSD stipulate that “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others... [and where] the person’s

response involved fear, helplessness, or horror....” The symptomatology of PTSD can include intrusive re-experiencing of the traumatic events, ranging from nightmares to flashbacks; autonomic hyperarousal; numbing of responsiveness (including the avoidance of distressing internal sensations); intense emotional reactions, memory disturbance and psychosomatic reactions (APA, 1994).

According to Joseph, Williams and Yule (1995) “a traumatic event presents an individual with stimuli which, as perceived at the time, give rise to extreme emotional arousal but which cannot be immediately processed” (p.517). While it is natural for individuals to initially have a stress reaction to a traumatic event and perhaps be temporarily overwhelmed by it, those who go on to develop PTSD are often characterised by being “stuck” on the trauma which keeps them reliving it through thoughts, feelings and images. Another central feature of PTSD is that individuals will often avoid reminders of the trauma (van der Kolk and Ducey, 1984) thereby preventing the opportunity for integration of the distressing material.

Introducing Posttraumatic Growth

While the research into PTSD has contributed much to our understanding of how trauma can impact upon the individual, a recent shift within the literature has been to look more at adaptive adjustment. Collectively, this has been termed Posttraumatic Growth (PTG) (Tedeschi, Park and Calhoun, 1998). Here trauma has been defined more broadly than those typically identified as precursors to PTSD and includes horrific events such as life-threatening combat, confinement in concentration camps and childhood rape, as well as situations which do not

involve a direct threat to one's own life such as enduring the tragic death of a loved one, becoming disabled and the sudden break up of a marriage after many years (Calhoun and Tedeschi, 1999). According to Calhoun and Tedeschi, (1998), PTG is not just about bouncing back from trauma but is likened to a springboard to further individual development or growth. There are, however, a number of difficulties with the term PTG not least due to the overlap with a number of related terms and concepts. For example, PTG has also been described as 'positive psychological changes' (Yalom and Lieberman, 1991), 'thriving' (O'Leary and Ickovics, 1995) and 'stress related growth' (Park, Cohen and Murch, 1996). However, it is argued that where PTG differs is that it goes beyond being merely a coping strategy. Changes made can be such they may be experienced as 'truly transformative' not only for the individual but also, in some cases, for society as a whole (Bloom, 1998).

The literatures on PTSD and PTG portray very different images of what it might mean to have experienced trauma. The literature on PTSD highlights how for some individuals, experiencing trauma can have a devastating and lasting negative impact on the person's life, while the concept of PTG almost allows us to view trauma as a gift which could lead to positive change and transformation in many areas of one's life. It seems intuitively sensible that it is only once the individual has worked through and learnt to adapt to the trauma that PTG is likely to occur. However, recent research has found that distress and growth can co-exist (Calhoun, Park and Tedeschi, 1998) with people reporting both negative and positive responses to trauma (Joseph, Williams and Yule, 1993). The idea that one can benefit from stressful and traumatic life experiences is certainly not new

however it has been given little attention by comparison to the literature and research which has focused primarily on the negative and enduring aspects of trauma.

CONTRIBUTORY FACTORS AFFECTING POSITIVE OUTCOME FOLLOWING TRAUMA

In trying to understand trauma and its impact, the question as to why some individuals develop PTSD and others do not has generated much research. A number of theoretical stances have been advocated including emotional processing (Rachman, 1980), social cognitive perspectives (Janoff-Bulman, 1992) and information processing models (e.g., Horowitz, 1986; Foa and Riggs, 1993). The focus of much of this literature has been orientated around attempting to identify disorder-predictive factors (e.g., Brewin, Andrews and Gotlib, 1993; Cohen and Willis, 1985; Horowitz, 1976; Weiner, 1986). While exposure to a traumatic event is a necessary aetiological factor in the development of PTSD, there is some debate over what other factors may be associated with more severe distress. However, according to Joseph, Williams and Yule (1997) many of the factors or theories identified do not adequately account for the full range of symptoms associated with the diagnosis of PTSD. To better understand individual differences and how certain factors contribute to the development and maintenance of PTSD, Joseph et al (1997) have developed an integrative psychosocial model of PTSD and individual adjustment, which takes account of the following factors: Personality and individual history; emotional states at the time of the event and subsequently; the objective nature of the event characteristics; the individual's appraisals of the event and of their emotional

states and coping behaviours; and the responses and coping behaviours of others in the post-trauma environment. This model moves us closer to an understanding of how positive and negative aspects of the trauma experience co-exists (for a full explanation of this model see Joseph et al, 1997).

In taking a closer look at the possible contributory factors of individual outcome following trauma, attention is given next to the literature related to PTG. The aim of this approach is to provide a broader and more salutogenic focus to trauma by exploring how some people seem more able to adjust and cope with trauma than others. The literature reviewed in this area relates largely to the functioning of adults who have experienced traumatic events and self-perceived life crises. Exploring the growth literature rather than relying solely upon the disorder literature may allow us to see how we might move towards helping those who continue to suffer in the aftermath of trauma.

Using the psychosocial model of adjustment (Joseph et al, 1997) as a framework, the following factors will be explored: Personality and individual history; emotional states at the time of the event and subsequently; the objective nature of the event characteristics; the individual's appraisals of the event and of their emotional states and coping behaviours; and the responses and coping behaviours of others in the post-trauma environment. The literature reviewed here draws upon the intrapersonal (Tennen and Affleck, 1998), contextual (Schaefer and Moos, 1992), interpersonal and social forces (Bloom, 1998) that may affect experiences of adjustment, change and transformation.

Personality and individual history

The role of personality characteristics in influencing positive outcome has been given some attention within the literature. For example, a study of 44 survivors of the Perth flood (Morgan, Matthews and Winton, 1995) showed the importance of personality features especially neuroticism in promoting the severity of symptoms. One area consistently linked to adaptive outcome is an internal locus of control. Individuals who perceive outcomes as being more under their personal control rather than under the control of external factors are more likely to show evidence of personal growth and to be more likely to find benefits in adverse events (Wollman and Felton, 1983). Focus has also been given to the personality dimensions of dispositional hope and optimism (O’Leary and Ickovics, 1995; Snyder, Irving and Anderson, 1991), cognitive self-complexity (Linville, 1987) and the Big Five dimensions of personality (i.e., neuroticism, extraversion, openness to experiences, conscientiousness and agreeableness). For example, McCrae and Costa (1986) found that individuals low in neuroticism, high in extraversion, and high in openness tend to rely to a greater extent on drawing strength from adversity as a style of coping with threat. One central problem of this work is the lack of assessment of personality prior to the traumatic event (Abramson, Metalsky and Alloy, 1989) and therefore reliance upon retrospective reports. Tennen and Affleck (1998) highlight that “individuals who already experience a sense of personal control, who are optimistic about the future, who are outgoing and open to new experience, who are confident in their coping capacities and who view the world as meaningful... are, according to current theory, most likely to emerge from a crisis or traumatic experience in some way better than they were prior to the experience” (p76).

Given that our personality is shaped by our life experiences, much of the literature has focused upon those experiences both in childhood and adulthood found to affect later adjustment. While the PTSD literature has tended to focus more upon vulnerability factors leading to maladaptive adjustment (such as prior behavioural and psychological problems (North, Smith and Spitznagel, 1994) and adverse childhood experiences (Brewin, Andrews and Gotlib, 1993), there exists a body of research, which has focused more on factors of resilience and more adaptive adjustment (e.g., Aldwin and Sutton, 1998; Antonovsky, 1987; Kobasa, 1979; Werner, 1989; Rutter, 1987). For example, prior experience with and mastery of life crises and stressful events can boost people's self-efficacy and enhance coping resources (e.g., Bandura, 1982; Rutter, 1987).

Emotional states at the time of the event and subsequently

During the traumatic event and for some time afterwards the individual is likely to experience many different emotions such as fear, anxiety, grief, guilt, anger and shame. These emotional states can be understood as relatively normal responses to an abnormal situation. Much of the literature on emotional states has tried to explore the relationship between acute stress reactions and PTSD, however, while there is some evidence of a causal link (Solomon, 1993) not all those who develop an acute stress disorder go on and develop PTSD (Joseph et al, 1997). Though, if the individual feels threatened by their emotional reaction (Horowitz, 1976) or if they are totally overwhelmed by negative emotions or feel them to be inappropriate, then the processing of the traumatic material may be blocked due to their need for self protection. Behavioural inhibition, concealment and denial are often processes by which the self is protected from the experience of distress

(Joseph et al, 1997). One interesting theme within the PTG literature concerns the relationship between psychological distress and growth. While it seems sensible to assume that psychological distress inhibits PTG at least in the short-term, psychological distress has also been found to be a catalyst for change, arousing personal resilience and stimulating new coping efforts and more social resources (Schaefer and Moos, 1998).

The objective nature of the event characteristics

Generally, trauma is most often associated with events which are sudden, unexpected, perceived as undesirable and uncontrollable, out of the ordinary and threatening to one's life and general well-being (McCann and Pearlman, 1990; Tennen and Affleck, 1990). Characteristics of the trauma or crisis may include differences in its nature and severity; amount of personal exposure; extent of loss and scope of loss (e.g., whether it affects just the individual, or family or whole community); and access to help (Schaeffer and Moos, 1998). While much literature exists on the traumatic characteristics that make them a threat to psychological adjustment and well-being, it is not clear which are associated with PTG (Tedeschi, Park and Calhoun, 1998). According to Tedeschi, Park and Calhoun (1998) growth can only come from events that successfully 'shake the foundations' or in some cases 'shatter' the individual's assumptive world (Janoff-Bulman, 1992). Current unresolved questions concern whether there is a minimum threshold of disruption which has to be crossed in order for growth to occur and whether subsequent growth is dependent upon the perceived stressfulness of the event.

The individual's appraisals of the event and of their emotional states and coping behaviours

It is well documented that attributional perspectives invoking constructs of uncontrollability and unpredictability have led the way in terms of the development of explanations about how individuals perceive traumatic events (Dunmore, Clark and Ehlers, 1997; Foa, Zinbarg and Rothbaum, 1992; Janoff-Bulman and Frieze, 1983; Riggs, Foa, Rothbaum and Murdock, 1991). According to Joseph, Yule and Williams (1993) causal attributions and attributional style may be related to specific emotional states within PTSD and to particular coping behaviours. Therefore as previously stated those individuals who are able to maintain a sense of control and perceive the situation as manageable tend to adjust and cope better with trauma (Tennen and Affleck, 1998). In addition and drawing upon a stress and coping framework, Schaeffer and Moos (1998) point out that individuals who appraise a life crisis as a challenge that they can master may cope more actively with the problem and be more likely to grow from the experience.

To better understand the adaptive value of appraisals of personal growth under threat it is important to acknowledge how our views of ourself and the world can be affected by trauma. Janoff-Bulman and Freize (1983) highlight how our personal theories allow us to set goals, plan activities and order our behaviour. While we may perceive ourselves as having control over events, being relatively invulnerable to harm and believe the things that happen are predictable and meaningful, this processing generally does not come into consciousness unless it is threatened or challenged in some way (McCann and Pearlman, 1990). It is argued that the very questioning of basic assumptions provides the context for

personal change through the task of rebuilding an assumptive world to accommodate new realities (Tennen and Affleck, 1998). This process of cognitive adaptation (Taylor, 1983) or cognitive reappraisal (Rothbaum, Weisz and Snyder (1982) allows for new meaning to be found. Janoff-Bulman (1992) describe three aspects of adaptive posttraumatic reappraisal: lessons about life, lessons about self and benefits to others. Such lessons can include greater awareness and appreciation of their strength, courage or wisdom.

Coping with trauma has been widely researched (e.g., Irving, Telfer and Blake, 1997; McMorris, 1998; Reynolds and Brewin, 1998; Schaeffer and Moos, 1998; Valentiner, Foa, Riggs and Gershuny, 1996). Among the myriad of coping responses delineated in the literature, two main types of coping strategies are important in the current context – avoidance coping and approach coping. Avoidance coping refers to attempts at minimizing the problem, believing nothing can be done to change the problem itself, seeking alternative rewards and venting emotions. Approach coping on the other hand, refers to attempts at trying to analyse the crisis in a logical way, reappraising the crisis in a more positive light, seeking support and taking actions to solve the problem (Schaeffer and Moos, 1998). As avoidance coping is characteristically an aspect of PTSD, an approach or adaptive coping style that also allows for emotional and cognitive processing, has been found to reduce PTSD symptomatology (e.g., Arias and Pap, 1999; Bryant, Marosszeky, Crooks et al, 2000; Clohessy and Ehlers, 1999) and lead to greater adjustment and well-being for the individual (see Wolfe, Keane, Kaloupek and Mora, 1993). Indeed perceptions of benefits or growth may be a positive outcome of coping transactions (Taylor, 1983).

The responses and coping behaviours of others in the post trauma environment

Environmental characteristics have also been suggested to be important in terms of how well one will adjust to the trauma (Benotsch, Brailey, Vasterling et al 2000). This includes the individual's relationship with and social support from family members (e.g, Grummon, Rigby, Orr and Procidano, 1994), friends and colleagues, as well as aspects of their financial, home and community situation (Schaeffer and Moos, 1998; Puddifoot, 1995). It is suggested within the literature that with respect to event-related factors, people who experience more severe events often receive more support (e.g., Zemore and Shapel, 1989). Social support and the reactions of others are recognised within both the PTG and PTSD literatures (see Joseph et al, 1997) with considerable evidence that social support has stress-buffering effects (e.g., Dalgard, Bjork and Tambs, 1995; Roy and Steptoe, 1994). While, seeking and receiving social support is clearly advantageous, such support may not always be forthcoming. This may be particularly so for traumas, such as child sexual abuse in which significant others may have difficulties in accepting the possibilities that such events may occur within their own assumptive worlds (see Woodward and Fortune, 1999). Additional factors found to play a role in terms of reactions to trauma and subsequent well-being include cultural and societal factors (e.g., Adriance, 1999; Monteiro, Guluma and Macaulay 1999; Stamm B and Stamm H, 1999; Nader, Dubrow and Stamm B, 1999; Peddle, 1999). Closely linked to cultural factors are issues concerning the role of religion and spirituality in helping individuals cope with traumatic events (e.g., Dreshman-Chiodo, 1997; Fallot, 1997; Humphreys, Lee, Neylan and Marmar, 1999; Walsh, 1999).

According to Shaeffer and Moos (1998), PTG comprises a dynamic interplay of factors: the nature of the crisis, personal and environmental resources and how the individual perceives and copes with the crisis. In addition, it appears from the literature that additional cultural, religious and spiritual factors may, for some individuals, influence their coping and their subsequent adjustment to traumatic events.

POSITIVE RESPONSES TO TRAUMA

One question from the literature concerns whether it automatically follows that individuals suffering from PTSD will have exclusively negative responses to the trauma. In the preliminary development of a measure to assess positive and negative responses, Joseph et al (1993) reported being surprised by the large numbers of survivors (of the Herald of Free Enterprise disaster) who endorsed the positive response items. The identification of positive consequences from traumatic experiences has been found in diverse areas such as bereavement (Calhoun and Tedeschi 1990); cancer (Collins, Taylor, Skokan, 1990); disasters (Thompson, 1985) and rape and sexual abuse survivors (Brown, 1998; Burt and Katz, 1987). For example, Brown (1998) found that perceived positive impact of the sexual abuse experience (e.g., improved self understanding, empathy for others) was inversely associated with trauma symptoms, suggesting that perceiving benefit may have a valuable effect on adjustment.

Positive changes and personal growth

While there has been early recognition that positive changes can arise from traumatic experiences (e.g., Caplan, 1964; Fromm, 1947 and Yalom, 1980) it has only been recently that systematic investigation into the concept of PTG has taken place (O’Leary and Ickovics, 1995). The work of Tedeschi and colleagues (1998), have identified three main areas where change and growth can exist: changes in perception of self, changes in relationships with others, and a changed philosophy of life.

Changes in perception of self

Changes in one’s sense of self reflect how one sees and feels about who they are in the aftermath of the trauma and have importance in promoting PTG. For example, moving from ‘victim’ to ‘survivor’ status (Epstein, 1990; Woodward, 1999), greater awareness of self-reliance (i.e., “if I survived this, I can handle anything”) (Aldwin, Levinson and Spiro, 1994) and somewhat paradoxically a heightened awareness of one’s vulnerability. The benefits of increased awareness of vulnerability that exist alongside positive changes in views of self can lead to positive changes in interpersonal relationships, appreciation of life and priorities for spending one’s time (Tedeschi, Park and Calhoun, 1998). Similarly the realisation that bad things can happen *to me*, thereby highlighting one’s sense of vulnerability can serve to correct the more unrealistic belief that *it can’t happen to me* (Calhoun and Tedeschi, 1990). This moves us away from the notion that PTG is simply about positive illusions as many people who go through PTG develop a more realistic appraisal of the vagaries of the world.

Changes in relationships with others

Many people report a strengthening of their relationship with others following a trauma or crises (Affleck, Tennen and Gersham, 1985). One possible contributory factor to this is that some individuals engage in greater self-disclosure and emotional expressiveness (Dakof and Taylor, 1990) thus improving communication and intimacy. The ability to express feelings and disclose important personal information, is shown to be related in positive ways to various indices of mental and physical health (see Pennebaker, 1995). It has however been noted that expressiveness and openness may not always be the most helpful strategy in all situations especially in areas of rape and childhood sexual abuse (e.g., Frazier and Burnett, 1994). Tedeschi, Park and Calhoun (1995) suggest what may have been learnt is better recognition of who can be safely trusted. Similarly, experiences of victimisation by a trusted person, possibly presents a more complicated path to growth in areas of interpersonal relationships. Moreover, vulnerability may create empathy and greater compassion for others which can result in a desire to give more to others.

Changed philosophy of life

Changes to one's philosophy of life have also been noted in terms of priorities and appreciation of life, existential themes and sense of meaning and spiritual development. Experiencing trauma especially traumatic events where one's life is threatened, can lead one to appreciate much more the value of life and everyday living (Tedeschi and Calhoun, 1998). This in turn can lead to changes in life priorities (see Joseph et al, 1993). Furthermore it is suggested that experiences of

growth may involve spiritual, religious or existential changes (Calhoun and Tedeschi, 1998; Yalom and Lieberman, 1991).

THE SEARCH FOR MEANING AND THE IMPORTANCE OF PROCESSING AND INTEGRATING TRAUMATIC MEMORIES

Trauma and suffering have long been recognised within the existential and humanistic psychology literature as an opportunity for personal development and growth and where meaning can be created (Jaffe, 1985; Kessler, 1987; Kierkegaard, 1983). As previously explored, the impact of trauma can challenge one's ability to make sense of and find meaning in one's life (Calhoun and Tedeschi, 1999). Recent theoretical work in traumatic stress emphasises the importance of maintaining and restoring such beliefs. Similarly being able to make sense of one's experience of trauma is recognised as a critical factor in promoting adjustment and growth (see Calhoun and Tedeschi, 1998; Janoff-Bulman and Frantz, 1997; Lindy-Jacob, 1996; Woodward, 1999).

Adjustment and growth are further strengthened if one is able to find some benefit in the experience (see Davis, Nolen-Hoeksema and Larson (1998). For example, Janoff-Bulman and Frantz (1997) write about the drive to find a meaningful life out of a meaningless world, while Lindy-Jacob (1996) advocates that the most important contribution of psychodynamic treatments have been their focus on the understanding of the subjective meaning of the traumatic event, and the process (and barriers to) the integration of the experience with pre-existing attitudes, beliefs and psychological constructs. For some individuals, assimilating the traumatic experiences can be extremely difficult. However, many research studies

have found that if the traumatic memories can be emotionally processed and integrated, this has a direct impact upon PTSD symptomology (e.g., Arias and Pap 1999; Bryant et al 2000; Clohessy and Ehlers, 1999; Costello, 1998;). Costello (1998) found that simply expressing negative feelings is not enough for cognitive-affective integration and recovery to occur. Instead interventions which facilitate the expression of negative feelings while decreasing avoidance strategies and improving cognitive change and insight may be the most helpful.

Two interesting themes within the PTG literature concern 1) whether PTG arises out of effortful or automatic processes; and 2) whether PTG is an abrupt or gradual process. Current theories of adaptation to traumatic events describe both automatic processes and deliberate efforts. According to Horowitz (1986) almost all who have experienced trauma attempt to control the extreme emotional reactions that accompany traumatic experiences. An additional need is to disengage from beliefs, goals and related activities that no longer make sense. Rumination, the process of frequently returning to thoughts of the trauma and related issues, is seen as part of the disengagement process. Within Horowitz' theory is the notion of 'dosing' where the timing, frequency and duration of trauma related thoughts and images are controlled. Dosing permits the person to choose what information about the trauma will be considered or disregarded at any moment in time, including information about one's newly discovered strengths. However this model excludes conscious efforts to manage threatening images and information.

Building on the work of Horowitz, Janoff-Bulman (1992) distinguishes two cognitive processes that help individuals pace their cognitive integration of the traumatic experience. Trying to re-evaluate the trauma as imparting personal strength, wisdom, or other growth-related characteristic is an example of deliberately trying to reinterpret the event so as to maintain cherished assumptions about oneself, the world and the future (Tennen and Affleck, 1998). In addition, Calhoun and Tedeschi (1998) highlight that PTG is more likely to occur when first there is an automatic rumination followed by a more deliberate process. This sequence is seen as offering “a balance of affective and intellectual elements where learning from the trauma may have its greatest and most constructive impact” (p.231).

Prevalence rates for PTSD illustrate that many people who have experienced some form of trauma do not develop PTSD. They are able to cope with and adjust to the trauma and move on in their lives. Moreover, some of these individuals are able to go one step further and find that as a result of having survived their traumatic experiences they recognise within themselves positive changes and personal growth. For example, approximately 50% of people who experience life crises report some benefits from them (Schaeffer and Moos, 1992). However, others are not able to process and integrate their traumatic memories and remain ‘stuck’ or ‘blocked’ within the trauma.

TREATMENTS FOR PROCESSING AND INTEGRATING TRAUMATIC MEMORIES

Identifying where and how an individual may be “stuck” or “blocked” in the processing of distressing information is central to the planning of treatment. Various interventions have been introduced to help individuals who have experienced traumatic experiences, such as Critical Incident Stress Debriefing (Mitchell, 1983), psychopharmacological treatments (e.g. Davidson, 1992; Nagy, Morgan, Southwick and Charney, 1993) and psychotherapeutic treatments (e.g., Costello, 1998; Goldfinger, 1999; Tarrier, Pilgrim, Sommerfield et al, 1999). Such treatments have largely focused upon enabling the individual to 1) process and integrate the traumatic experiences, 2) control and master physiological and biological stress reactions, and 3) re-establish secure social connections and interpersonal efficacy. Moreover, it has now been recognised that trauma needs to be treated differently at different phases of people’s lives and at the different stages of PTSD (Foa, Rothbaum, Riggs and Murdock, 1991). While recognition is given to psychotherapeutic treatments, in helping the individual to make sense of their traumatic experiences, the literature reviewed next focuses on cognitive behavioural approaches such as cognitive restructuring, anxiety management and exposure techniques as these have been found to be particularly helpful in alleviating many of the symptoms of PTSD (Rothbaum, Meadows, Resick and Foy, 2000). As research suggests that some patients may find some of the components of cognitive behavioural approaches overwhelming (e.g., Tarrier and Humphries, 2000), attention will also be given to Eye Movement Desensitisation

and Reprocessing (EMDR) as a technique that may permit individuals to process and integrate traumatic cognitive sequelae.

The most widely researched treatment is the cognitive behavioural approach (e.g., Brom, Keber and Defares, 1989; Foa et al, 1991; Marks, Lovell, Noshirvani et al, 1998; Richards, Lovell and Marks (1994). Drawing upon the emotional processing model (Foa, Steketee and Rothbaum, 1989) which states that avoidance of traumatic material results in a memory which is “unprocessed”, techniques such as cognitive restructuring, anxiety management and exposure (including systematic desensitisation (Muse, 1986), flooding (Keane, Fairbank, Caddell and Zimmering, 1989), image habituation training (Vaughan and Tarrier, 1992) and prolonged exposure (Foa et al, 1991); have been used to help the individual understand, manage and process the traumatic material. Despite cognitive therapy having been used for a wide variety of disorders, it has only recently been used for PTSD (Thrasher, Lovell, Noshirvani and Livanou, 1996). Nevertheless, it is concluded from the studies conducted that exposure based therapies are effective for many symptoms of PTSD with increasing evidence that cognitive interventions alone are useful for PTSD (e.g., Resick and Schnicke, 1993; Richards and Lovell, 1999). Whilst exposure based treatments are an effective means by which individuals confront and process that which they most wish to avoid (i.e., traumatic stimuli), the exposure process can bring with it a degree of distress. Tarrier et al (1999) found that of the 20% of patients who failed to show an improvement after treatment, a significantly greater number of these patients received exposure treatment than cognitive therapy.

At least two significant problems of the exposure technique have been highlighted: 1) Excessive arousal impedes habituation because it interferes with acquisition of new information; and 2) the strong response elements in PTSD structure may promote avoidance. It is suggested that when excessive arousal occurs, the fear structure will not be corrected, but instead, will be confirmed: instead of promoting habituation, it accidentally fosters sensitisation. In addition, fear and discomfort may motivate people who suffer from PTSD to avoid or escape confrontation with situations that are reminders of the trauma. In order to overcome the intrusive, sensorimotor elements of the trauma, a person must transform the traumatic (non-verbal) memory into a personal narrative, in which the trauma is experienced as a historical event that is part of a person's autobiography. This entails being able to tell the story of the trauma without re-experiencing it. While integration of the distressing material is often regarded as the intended outcome for successful therapy, Foa and Kozak (1985) argue that the critical issue in treatment is to expose the individual to an experience that contains elements that are sufficiently similar to an existing traumatic memory in order to activate it, and at the same time for it to be an experience that contains aspects that are incompatible enough to change it (for example experiencing a traumatic memory in a safe and controllable environment, being able to evoke a traumatic image without feeling overwhelmed by the associated emotions). It is generally assumed that once all relevant elements of the total traumatic experience have been identified and thoroughly and deeply examined and experienced in therapy, successful synthesis will take place (Resick and Schnicke, 1992). However, if some traumas are too traumatic to face could we be asking too much of our clients to expect them to explore that which they most fear, unless we can give them the

means by which they can re-experience the trauma without experiencing its full intensity?

A new treatment that appears to address this concern is Eye Movement Desensitisation and Reprocessing (EMDR). Since the early nineties there has been a growing body of research into EMDR, which has attracted much attention and controversy. The application of EMDR has been widely applied to a variety of different problems but which mostly centre upon PTSD, grief reactions and generalised anxiety (e.g., Brown, McGoldrick and Buchanan, 1997; Carrigan and Levis, 1999; Feske and Goldstein, 1997; Scheck, Schaeffer and Gillette, 1998). Despite the growing popularity of EMDR amongst clinicians and the number of case studies which have reported phenomenal success with this approach, often over short periods of time, EMDR has been widely criticised. These criticisms are clearly outlined within the literature and can be found mostly within a number of review papers (e.g., Hudson, Chase and Pope, 1998; Lohr, Likienfeld, Tolin et al 1999; Muris and Merckelback, 1999). Conversely, there is also a wealth of studies reporting significant findings using EMDR (e.g., Carlson, Chemtob, Rusnak et al, 1998; Grainger, Levin, Allen-Byrd et al, 1997; Wilson, Becker and Tinker, 1997; Scheck et al, 1998; Shapiro, 1996).

PROMOTING POSTTRAUMATIC GROWTH

Regardless of the treatment approach employed, being able to process and integrate traumatic memories is integral to the recovery process. While some individuals remain unable to move on from their traumatic experiences, for others

the recovery process affords the opportunity for positive change and personal growth. In treating trauma survivors it is advocated that the clinician needs to be open to the idea of PTG and that this can be a possible addition to the treatment process. However it is important to note that not everyone will go on and experience PTG and for some individuals, the mere idea of there being any benefits to the traumatic experiences may be totally incomprehensible at this time. Encouraging PTG has to be handled carefully and sensitively. Promoting PTG is not a new treatment and can be applied to any theoretical orientation (Calhoun and Tedeschi, 1998). The promotion of PTG has generally not been noted in most treatments for trauma survivors (Meichenbaum, 1994). In their work (Calhoun and Tedeschi, 1991; Tedeschi and Calhoun, 1995; Calhoun and Tedeschi, 1999) Calhoun and Tedeschi outline how clinicians can encourage PTG. In brief, this requires: (1) the clinician to be open to the possibility of growth; (2) to be willing to go on existential journeys with clients as they try to discover meaning in their experiences; (3) to be open to discussing both spiritual and religious issues; and (4) to recognise and support the individuals' idiosyncratic views of their trauma and growth and not focus simply on the alleviation of symptoms.

The central theme of this literature review has been about the importance of promoting posttraumatic growth. This review has attempted to draw together a number of somewhat disparate literatures on PTSD, coping, adjustment and psychological treatments in an attempt to provide a background for introducing and understanding the concept of posttraumatic growth. Processing trauma occurs within the concrete contexts and material conditions of people's everyday lives and is constrained not only by symptoms and one's biopsychosocial

reactions to them, but also by an existential search for meaning within the trauma experience. Individuals and families attempt to make sense of their experiences and process their trauma through a variety of means that would appear to involve more than just 'positive illusions'. Posttraumatic growth may be reflective of a deeper and perhaps wiser understanding of the self in the aftermath of trauma.

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Chapter II

Exploring the role of eye movements in Eye Movement
Desensitization and Reprocessing: Testing a working
memory model of “distress reduction”

Summary

Objective: The present study set out to explore whether eye movements as used within Eye Movement Desensitization and Reprocessing (EMDR) plays a role in reducing the vividness and emotiveness of personal images and also to replicate a previous study by Andrade, Kavanagh and Baddeley (1997).

Design: A within subject experimental design was employed based upon previous studies and the working memory theory of ‘distress reduction’. The experiment was conducted on three groups (individuals with a diagnosis of PTSD, University Staff and Students).

Methods: Using dual task conditions, participants were asked to recall a number of images (visual and auditory) with positive and negative connotations as they did concurrent tasks (saccadic eye movements, counting and a control condition).

Results: Main effects were found for 1) stimulus ($F_{2,42} = 5.64$; $p = 0.007$) suggesting that auditory recollections had lower vividness and emotiveness scores than personal recollections and visual images, 2) condition ($F_{2,42} = 4.86$; $p = 0.013$) with eye movements or counting rated lower compared to the control condition, 3) valence ($F_{1,43} = 9.09$; $p = 0.004$) with negative stimuli rated lower than positive stimuli, and 4) vividness and emotiveness ratings, with emotiveness scores being rated lower than scores for vividness ($F_{1,43} = 21.55$; $p = 0.001$). While no significant interactions between the three conditions (control, counting and eye movements) and the groups were found ($F_{4,84} = .76$; $p > 0.05$), interactions were found between stimulus by group ($F_{4,84} = 3.19$; $p = 0.017$), stimulus by valence by group ($F_{4,84} = 2.57$; $p = 0.044$) and valence by ratings by group ($F_{2,43} = 4.27$; $p = 0.02$). In order to compare the results with Andrade et al (1997) separate 3 x 2 repeated measures Anova’s were conducted based on the total sample ($n=46$). Both eye movements and counting significantly reduced the vividness of positive personal recollections ($F_{2,90} = 6.30$; $p = 0.003$) and negative visual images ($F_{2,90} = 6.64$; $p = 0.002$). Counting was found to significantly reduce vividness scores on both positive ($F_{2,90} = 4.93$; $p = 0.01$) and negative auditory recollections ($F_{2,90} = 9.88$; $p = 0.001$). Emotiveness ratings showed no significant effects of the experimental manipulation.

Conclusion: The results of this study provide partial support for a working memory model of “distress-reduction”. In general, eye movements were not significantly better at reducing the vividness and emotiveness of visual stimuli than simple counting. This finding does not support the suggestion that eye movements are an essential component of EMDR.

Eye Movement Desensitisation and Reprocessing (EMDR) is a relatively new clinical technique that has been put forward as a means to help individuals reduce the intensity and intrusiveness of traumatic thoughts and images (e.g., Carlson, Chemtob, Rusnak et al, 1998; Grainger, Levin, Allen-Byrd et al, 1997; Wilson, Becker and Tinker, 1995; Scheck et al, 1998; Shapiro, 1989). The application of EMDR has been widely applied to a variety of different problems which mostly centre upon Posttraumatic Stress Disorder, grief reactions and generalised anxiety (e.g., Hudson, Chase and Pope, 1998; Scheck, Schaeffer and Gillette, 1998; Feske and Goldstein, 1997; Carrigan and Levis, 1999; Brown, McGoldrick and Buchanan, 1997). Despite the growing clinical evidence of the effectiveness of EMDR and its popularity among clinicians, a vigorous debate exists within the research literature regarding its empirical validity (see Hudson et al, 1998; Lohr, Likienfeld, Tolin et al 1999; Muris and Merckelback, 1999). While much of the controversy centres upon the efficacy of EMDR in comparison to other treatments, the question of the uniqueness of eye movements is of interest to the current study.

The usefulness of eye movements as an essential component of the therapy has been questioned by a number of authors (e.g., Cusack and Spates, 1999; Dunn, Schwartz, Hatfield and Wiegele, 1996; Hyer and Brandsma, 1997; Muris and Merckelback, 1999; Pitman, Orr, Altman, Longre, Poire and Macklin, 1996). Pitman and colleagues (1996) suggested that eye movements do not play a significant role in processing traumatic information in EMDR and that factors other than eye movements are responsible for EMDR's therapeutic effect. This view is further supported by Hyer and Brandsma (1997) who have argued that

EMDR is efficacious independent of the value of its component parts (e.g., eye movements) and is successful because it applies common and generally accepted principles of psychotherapy. Conversely a study by Feske and Goldstein (1997), while failing to show post treatment differences after three months of the EMDR treatment, reported that during treatment EMDR led to greater improvement than treatment omitting eye movements or a waiting list control. From this 'dismantling' research it is clear that further work is needed to look at whether eye movements do play an integral role in the therapeutic value of EMDR.

Whilst there is burgeoning clinical evidence of the effectiveness of EMDR, there is somewhat less of a convincing theoretical basis underpinning the treatment (MacCulloch and Feldman, 1996). An important set of studies by Andrade, Kavanagh and Baddeley (1997) addressed both these issues and found that not only did eye movements make personal recollections less vivid and emotive but they also identified a potential mechanism for understanding why this might be the case. By using the working memory framework of information processing (Baddeley, 1986) and dual task methodology, they suggest that there may be something therapeutically unique about eye movements. They write "a possible explanation is that eye movements disrupt imagery not only because of limitations to process capacity but also because of conflicting perceptual feedback to the visuospatial sketchpad for example produced by movement of stimuli across the retina. This possibility is supported by participants' reports that the eye movements 'blurred' the image" (p.220). The question asked by Andrade et al is if eye movements make images of experimental stimuli and personal recollections less vivid and less emotive, might they also reduce the vividness and emotiveness

of PTSD images? The clinical implications of this is that it might help some individuals who are otherwise too anxious to contemplate their trauma through standard exposure treatment to begin to face the distressing information without being overwhelmed by it.

Design and Methods

This within subject experimental design partly replicates and partly develops the experimental work of Andrade and colleagues. The study uses similar methodology to Andrade et al (1997) but differs in its design by the inclusion of a clinical population.

The purpose of this study was to explore whether eye movements as used within Eye Movement Desensitization and Reprocessing (EMDR) play a role in reducing the vividness and emotiveness of personal images.

Subjects

A clinical group of 9 adults identified as suffering from PTSD by secondary specialist health care professionals were recruited (mean age = 45.78, SD = 10.71). A further group of 16 students (mean age = 20.81, SD = 3.31) without PTSD were also recruited from Coventry and Warwick Universities. The experiment was also conducted on 21 staff members at Coventry University (mean age = 35.86, SD = 9.96) (see Appendices 1-7 for information regarding recruitment of subjects).

Materials

Prior to the experiment each participant was asked to select six stimulus materials of three types 1) photographs of people or places that have emotional associations for the participant, 2) auditory memories (e.g., song, poem) with emotional associations and 3) recollections of events (e.g. personal memories) with emotional associations that have happened in that participant's life (see Appendix 8).

Procedure

Participants were required to bring in stimuli that had positive and negative associations for them. These stimuli comprised three negative and three positive personal recollections, visual images and auditory recollections. This totalled 18 different types of stimulus for each participant.

Participants were provided with some guidance as to the selection of suitable material but choice was left to them. The concurrent tasks were provided in the form of three computer generated conditions: 1) The control condition comprised a blank grey screen except for a static black dot placed in the centre of the screen; 2) In the counting condition the participant was asked to sit in front of a blank screen and invited to count aloud down from 100; and 3) The eye movement condition comprised two black dots positioned left and right of the screen, which intermittently flashed resulting in saccadic eye movements for the participant.

At the beginning of the experiment the stimulus materials were ranked according to the level of emotiveness. Each stimulus material was given a label and the

information transferred onto a scoring sheet in preparation for the experiment. The order of the stimulus materials and conditions were counterbalanced to avoid practice effects. All participants underwent a pre trial to illustrate the procedure and method of scoring. During the experiment, participants were asked to sit at a blank computer screen and either look at a photograph or recall either an auditory or personal recollection for 20 seconds. After the 20 seconds, and still retaining the image participants did one of the three concurrent tasks for 8 seconds. A rating scale was then placed in front of the participant who called out a number relating to the vividness of the image (scored 0 - 10) (with 0 indicating no image or sound to 10 indicating a perfectly clear image or sound) and the emotiveness of the image (-10 to +10 with -10 being extremely negative to +10 being extremely positive).

Self-report Measure

After the experiment participants also completed the General Health Questionnaire (GHQ-28) (Goldberg, 1972) to assess current psychological distress. This measure is well established in relation to reliability, validity and normative data (see Appendix 9 for sample).

Hypotheses

The study attempted to investigate four main hypothesis. 1) 'Eye movements' will reduce both vividness and emotiveness of visual images but not auditory recollections, 2) 'Counting' will reduce both vividness and emotiveness of auditory recollections but not visual recollections, 3) 'Eye movements' and 'Counting' will reduce both vividness and emotiveness of personal recollections

and 4) The level of psychological distress will be positively correlated to the vividness and emotiveness of personal recollections.

Results

In order to address these hypotheses, an ANOVA was conducted. There were three within subject factors of stimulus (personal recollections, visual images and auditory stimulus), three within subject factors of condition (control, counting, and eye movements), two emotional valence factors (positive stimuli and negative stimuli) and two ratings factors (vividness and emotiveness). One between subjects factor (PTSD, staff and students) was also used in the analysis. Table 1 shows demographic data for the three groups.

Table 1. Demographic Data and Mean GHQ Scores for Participants

Variable	PTSD	Student	Staff
Mean Age	45.78(10.71)	20.81(3.31)	35.86(9.96)
Gender %	56.6 (F)	100 (F)	42.9 (F)
Female (F)/Male (M)	44.4 (M)		57.1 (M)
GHQ-28	31 (17.4)	17.88(8.58)	15.67(7.99)

Main effects were found for 1) *stimulus* (6.78 vs. 6.66 vs. 6.23; $F_{2,42} = 5.64$; $p = 0.007$) suggesting that auditory images were rated less vivid and emotive than personal recollections and visual images, 2) *condition* (6.18 vs. 6.53 vs. 7.08; $F_{2,42} = 4.86$; $p = 0.013$) with eye movements or counting rated lower on both vividness and emotiveness compared to the control condition, 3) *valence* (6.35 vs. 6.80; $F_{1,43} = 9.09$; $p = 0.004$) with negative stimuli rated lower than positive stimuli, and 4) *vividness and emotiveness ratings* with emotiveness scores rated lower than scores for vividness (6.14 vs. 7.01; $F_{1,43} = 21.55$; $p = 0.00$).

While no significant interactions between the three conditions (control, counting and eye movements) and the groups were found ($F_{4,84} = .76; p > .05$), interactions were found between stimulus by group ($F_{4,84} = 3.19; p = 0.017$), stimulus by valence by group ($F_{4,84} = 2.57; p = 0.044$) and valence by ratings by group ($F_{2,43} = 4.27; p = 0.02$). Unsurprisingly a profile plot revealed that subjects with PTSD tended to rate the stimulus (whether personal and auditory recollections or visual imagery) higher than the Staff or Student group. In exploring the interaction between valence (positive and negative stimuli), ratings (vividness and emotiveness) and group (PTSD, Staff and Students) a non significant trend was found whereby PTSD subjects rated negative stimuli as more emotive ($F_{2,43} = 3.11; p = 0.054$) regardless of the condition.

To investigate the previously discerned differences between the groups and stimulus, scores on the GHQ28 were incorporated as covariates and the analysis of variance repeated. The apparent difference between stimulus and group ($F_{4,84} = 3.19; p = 0.017$) disappeared once GHQ28 scores had been added. This suggests that psychological distress was influencing stimulus ratings. One inference that can be drawn is that PTSD subjects' personal images and recollections may have been initially stronger than either the staff or student groups.

In order to compare the results with Andrade et al (1997) separate 3 x 2 repeated measures Anova's were conducted based on the total sample (n=46). Table 2 shows the mean vividness and emotion ratings for the negative and positive

personal recollections, negative and positive visual images and negative and positive auditory recollections.

Table 2. Effect of Conditions (Control, Counting and Eye Movement) on Vividness and Emotiveness of Personal Recollections, Visual Imagery and Auditory Recollections (standard deviations in parentheses)

		Stimuli					
		Personal Recollections		Visual Imagery		Auditory Recollections	
Rating	Condition	Positive	Negative	Positive	Negative	Positive	Negative
Vividness	Control	7.63(1.72)	6.93(2.27)	7.61(1.84)	7.57(1.81)	7.04(1.96)	7.37(2.02)
	Counting	6.70(2.07)	6.35(2.52)	7.50(2.03)	6.46(2.46)	6.17(2.77)	5.59(2.55)
	EM*	6.57(1.76)	6.83(2.35)	7/04(1.90)	6.76(2.07)	7.15(2.24)	6.59(2.15)
Emotion	Control	6.74(2.20)	6.13(2.44)	6.80(2.50)	6.11(2.33)	6.22(2.67)	5.65(2.69)
	Counting	6.13(2.44)	5.61(2.62)	6.57(2.46)	5.30(2.71)	5.63(2.43)	4.93(2.80)
	EM	6.37(2.08)	6.28(2.55)	6.33(2.76)	5.59(2.48)	5.98(2.54)	5.13(2.73)

* EM = eye movements

Personal recollections

Planned comparisons showed that whilst both eye movements and counting significantly reduced the vividness of positive personal recollections compared to the control group, eye movements were not significantly better than counting (6.57 vs. 6.70 vs. 7.63; $F_{2,90} = 6.30$; $p = 0.003$).

Visual images

Again both eye movements and counting significantly reduced the vividness of negative visual images (6.76 vs. 6.46 vs. 7.57; $F_{2,90} = 6.64$; $p = 0.002$). Pairwise comparisons suggested no significant differences between eye movements and counting ($p > .05$).

Auditory recollections

Compared to the control condition, counting significantly reduced the vividness of both positive (6.17 vs. 7.39 vs. vs 7.15; $F_{2,90} = 4.93$; $p = 0.01$) and negative auditory recollections (5.59 vs. 7.37 vs. 6.59; $F_{2,90} = 9.88$; $p = 0.001$).

Discussion

While this study successfully replicated the experimental design of Andrade et al (1997), mixed results were found which only partially supported the working memory model of “distress-reduction”. Results suggest that the effects of the experimental tasks undertaken by participants (eye movements or counting) had some effects on particular domains of performance as would be predicted by the working memory model and dual representation theory (DRT). For example, a significant effect on ratings of the vividness of auditory recollections was evident for counting – a verbal task, while eye movements had significant effects in the visual domain. However, although eye movements had no effect in the verbal task, counting did have an effect in the visual domain. This therefore suggests that eye movements appear no different to counting in reducing the vividness of personal recollections and visual images. While eye movements did make images less vivid, thus supporting Andrade and Baddeley’s (1993) finding that visuospatial tasks reduce the vividness of visual imagery, the results are not clear-cut. Negative visual images were rated as less vivid although this was not the case with visual images, which had positive connotations.

There is some evidence that modality-specific effects (of auditory recollections) were evident for the modality-specific condition of counting thus supporting one aspect of DRT (Brewin, 2001; Brewin, Dalgleish & Joseph, 1996) in that the verbal task would be expected to show capacity-interference in the auditory domain. However, it would be expected that counting would not affect the visual domain, given that DRT postulates that situationally accessible memory formation uses visuo-spatial rather than verbal information. Subsequently, the visual domain would not be blocked by the verbal task. This did not prove to be the case. Findings are further confused in relation to personal recollections. Once again eye movements and counting made personal recollections less vivid but only in relation to positive recollections. While this suggests that the dual tasks have some effect over past images as well as present ones (supporting Andrade et al, 1997) this did not apply equally to both positive and negative recollections. One might suspect that past negative recollections reflect more an over-told story where negative autobiographical memories may have been replayed and processed in a different way to positive memories, thus making the memories stronger to begin with.

Similarly with Andrade et al's study it was hypothesised that tasks which made images less vivid would also make them less emotive. Although Andrade and colleagues did find some evidence that eye movements did reduce the emotiveness of personal recollections this was not borne out by our study. Furthermore there were no significant findings in relation to the three groups, although a trend was found suggesting that PTSD subjects rated negative images as more emotive.

One of the main aims of this study was to investigate whether and to what extent eye movements could be considered to be an essential component of the EMDR treatment. The current study provides further evidence (e.g., Cusack and Spates, 1999; Dunn, Schwartz, Hatfield and Wiegele, 1996; Hyer and Brandsma, 1997; Muris and Merckelback, 1999; Pitman, Orr, Altman, Longre, Poire and Macklin, 1996) that there may not be anything therapeutically portentous about the value of eye movements as an essential part of the EMDR technique.

Given the inference drawn that for PTSD subjects their personal images and recollections were stronger and associated with greater psychological distress, components of EMDR, such as saccadic eye movements, may not be enough in themselves, to reduce the vividness and emotiveness of such powerful memories over and above counting and control conditions.

There are some limitations to the study, which limit the inferences that can be drawn from the results. In particular, reference must be made to the relatively small number of PTSD participants. Nonetheless partial support is given to the working memory of “distress reduction” model, although the uniqueness of eye movements was not fully borne out by the results of this study.

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Chapter III

Positive Change Processes in Personal Experience Narratives of Posttraumatic Growth

The concept of posttraumatic growth (PTG) is a new and emerging area of traumatology, which is concerned primarily with the potential for positive and beneficial effects of the experience of trauma. Much of this research has reported upon PTG outcomes, and has tended to rely upon the use of pre-defined questions to assess PTG. Subsequently less is known about how growth might actually occur outside of this framework. This study aims to explore themes of posttraumatic growth within personal experience narratives of individuals who have experienced self-perceived trauma. Using thematic analysis, areas of positive change and personal growth were found within the narratives, along with themes related to positive change processes, which were organised into three domains, 1) inner drive and motivation, 2) vehicles of change and 3) inner changes. The narratives reveal a range of lived experiences showing that positive change and personal growth emerge from trauma in the ebb and flow of people's everyday life. Such material contexts have implications for helping clients to harness their own 'inner wisdom for healing' as a means of facilitating posttraumatic growth.

It has been well documented that traumatic experiences can have devastating consequences for those affected both in the short and longer term (e.g., Solomon, 1993; Briere, 1992; Cahill, Llewelyn and Pearson, 1991; van der Kolk, 1984). Trauma can be defined as any crisis, event, stressor or tragedy that has an impact strong enough to lead the individual to experience a significant challenge to their ability to order, make sense of and find meaning in their lives (Janoff-Bulman, 1992). Events are often traumatic if they occur suddenly and unexpectedly (McCann and Pearlman, 1990), if they are regarded as being outside of the individual's control (Tennen and Affleck, 1990) and if the event involves physical harm or the threat of physical harm (Green, 1990). Furthermore the stage of development at which the stressful event occurs may also impact on its long-term nature, with childhood trauma more likely to produce serious long-term consequences for the individual (Calhoun and Tesdeschi, 1990). Much of the literature on trauma has tended to focus upon either the negative impact of trauma

as found within the extensive research available on Posttraumatic Stress Disorder (PTSD) (e.g., Benotsch, Brailey, Vasterling et al, 2000; Foa, Keane and Friedman, 2000; Horowitz, 1976, 1986, Janoff-Bulman, 1992; Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham and Barrowclough, 1999; van der Kolk, McFarlane and Weisaeth, 1996) or on the coping strategies employed to deal with traumatic experiences (e.g., Arias and Pap, 1999; Biro, Novvoic and Gavriolv, 1998; Reynolds and Brewin, 1998).

Given that any highly stressful situation has the potential to be experienced as traumatic (Dunmore, Clark and Ehlers, 1997; Janoff-Bulman and Frieze, 1983; Joseph, 1999), attention has therefore been given to notions of self-perceived trauma (see Oswalt and Silberg, 1995). Calhoun and Tedeschi (1999) highlight that although the frequencies of self-reported traumatic events vary across studies, exposure to highly stressful events is a common occurrence and subsequently a great percentage of persons will experience at least a significant loss, tragedy or catastrophe in a life time. However, two themes evident within the literature can be quite simply stated: 1) not everyone who experiences a traumatic event will go on and develop PTSD and 2) it is possible to cope, adjust and recover from traumatic experiences. This salutary perspective is further highlighted in a growing body of literature termed Posttraumatic Growth (PTG), which focuses on areas of positive change and personal growth as a result of traumatic experiences. Three main areas of growth have been identified: 1) changes in perception of Self; 2) changes in relationships with others; and 3) changes in people's philosophy of life (Tedeschi, Park and Calhoun, 1998). It has been found that any life crisis or traumatic event can spark PTG (Schaeffer and Moos, 1998) and as many as 40 -

70% of people who experience a traumatic event report some form of benefit from them (Calhoun and Tedeschi, 1999). Positive consequences of traumatic events have been found in diverse areas such as disasters (Thompson, 1995), bereavement (Collins, Taylor and Skokan, 1990), rape and sexual abuse survivors (Burt and Katz, 1987; McMillen, Zuravin and Rideout, 1995). Studies have found that perceiving benefit from trauma can have a valuable effect on adjustment and growth (Brown, 1998; Davis, Nolen-Hoeksema and Larson, 1998).

While studies have reported finding perceived benefits from traumatic events it has been argued that people tend to operate with certain “positive illusions” (Taylor and Brown, 1988) that make the world appear benevolent, safe, predictable and meaningful. Although such ‘illusions’ are seen as adaptive in enabling the individual to deal with their everyday life they are still “illusions” and therefore should not be taken at face value. According to Tedeschi et al (1998), PTG goes beyond being merely a coping strategy, as changes made are seen by some as being ‘truly transformative’ not only for the individual but also, in some cases for society as a whole (Bloom, 1998). It is further advocated that PTG is not just about bouncing back from trauma but is likened to a springboard to further individual development and growth. Given its phenomenological nature, the assessment and measurement of PTG is an area replete with complexities (Cohen, Hettler and Pane, 1998) not least because of “positive illusions”, but also because it includes the measurement of such variables as philosophy of life, values and religious beliefs. Some of the issues debated within the literature concern definitions of PTG, its timeframe in terms of when PTG should be measured and whether it refers to a process or outcome. While there

are problems inherent in both quantitative and qualitative assessments of PTG, several advantages of unstructured accounts are 1) individuals themselves can define what changes they believe constitute benefits and growth; and 2) through the process of the respondent telling his or her story it may become clear to the researcher how growth has occurred.

In trying to understand processes of change and growth a number of theories and models have been advocated which either focus upon change as intentional (e.g., Nerken, 1993; Mahoney, 1982) or else present change as sudden and unexpected (e.g., Hager, 1992; O'Leary and Ickovics, 1995; Tedeschi and Calhoun, 1995). While change and adaptation are of course necessary for survival (Chance, 1988), according to the humanistic tradition the one natural motivational force of human beings is the tendency to always be directed towards constructive growth. While many of the models are distinct, emphasis has been placed on areas such as the role of Self in reflecting upon experiences (Nerken, 1993), the need for periods of chaos to bring about growth (Hager, 1992) and the ability to integrate new material with change resulting from the pursuit, construction and alteration of meaning. Furthermore, a variety of personal and environmental resources were seen to enhance the likelihood of positive outcomes following life-changing or traumatic events. Although a number of the models have not been tested empirically and contain a number of methodological flaws, they have helped identify how some individuals might grow in the aftermath of trauma. However, it has been suggested that much further research is needed in this area (O'Leary, Alday and Ickovics, 1998).

The aim of this study is to explore themes of posttraumatic growth within personal experience narratives of individuals who have experienced self-defined traumatic events. Personal experience narratives are stories that people tell about their personal or 'lived experiences'. They differ somewhat from life stories (Plummer, 1995) in the sense that the personal experiences being written about may be in relation to only one or two significant events as opposed to the inclusion of many different events or episodes in a person's life. It is suggested that PTG can lead to the revision of fundamental schemas about self, others and the future, which appear as personal growth as a result of having to cope with trauma. Such schemas then become incorporated into personal narratives that give meaning to the trauma and consolidates perceptions of growth and transformation (McAdams, 1994; Tedeschi, 1999). Given that themes of change, growth and perceived benefit are mainly phenomenological in nature (Calhoun and Tedeschi, 1998), the employment of qualitative methods represents an appropriate means by which such concepts can be explored. Furthermore, there is a growing area of interest and recognition in the use of stories and narrative perspectives. Narratives are seen as a legitimate and valuable means by which a person's lived experience and the meaning which they give to their experiences of being in the world, can be explored, described and understood (e.g., Chessick, 1995; Danto, 1985; Dwivedi and Gardner, 1997; Jarman, Smith and Walsh, 1997; MacIntyre, 1985; Turpin, Barley, Beail et al, 1997; Sarbin and Kitsuese, 1994).

Method

Data Collection

Data was primarily collected as a result of an advert placed in the newsletter of the National Organisation for People Abused in Childhood (NAPAC) asking for people to write in with their story (see Appendix 10). The advert was worded in order that it was not too prescriptive in its focus. The aim was to give respondents control over what they chose to write about. The advert elicited 17 personal experience narratives. A further 12 respondents were recruited through 'word of mouth' and snowball sampling. Upon seeing the advert respondents either wrote in with their 'story' or requested further information about the study. All respondents received a personal reply, an information sheet about the study (see Appendix 11) and a brief background demographic sheet (see Appendix 12). The personal experience narratives received took the form of a letter, which averaged 7 pages (ranging from 1 to 37 pages). Fourteen letters were hand-written and 15 typed. Six respondents sent in two letters. Additional information received from respondents included poems, previously written documents, extracts from books and diaries and newspaper cuttings.

Participants

Twenty nine respondents were included within this study, 5 of whom were male and 24 female, aged between 22 and 72 years (mean age 39). Further demographic details of respondents can be found in Table 1 along with the types of traumas experienced (table 2, refers).

Table 1. Demographic Details of Respondents

Ethnicity	Only 1 respondent wrote that they were mixed race
Marital status	Married (n=10), Divorced (n=8), Single (n=6) Living with partners (n=3), Separated (n=2)
Education	Diplomas and other qualifications (n=8) Educated up to G.C.S.E/O'levels (n=6) Undergraduate degree (n=5), Postgraduate degree (n=5) A'levels (n=3), Not known (n=2)
Occupation	Counsellor, Psychotherapist or Clinical Psychologist (n=4) Secretarial/Administrators (n=4), Housewives/Mothers (n=4) Managers (n=3), Artists/writers (n=2), Teachers (retired) (n=2) Classroom assistant (n=1), Care assistant (n=1), Student (n=1) Software Specialist (n=1), Cook and Confectioner (n=1)
Religion	20 respondents stated that they were religious or spiritual in some way. 5 described themselves as Christian and 2 as spiritual. Religious status covered Church of England, Catholic, Anglican, Jewish, Quaker and Jehovah's Witness.

Table 2. Types of Trauma Experienced

All but 4 respondents stated that they had experienced childhood trauma, which took various forms but mostly involved sexual, physical and emotional abuse and neglect. In the majority of cases the abuse began from a young age and was of a long-standing duration. Perpetrators were mostly male family members but also included mothers and male adults outside the family. Several of these respondents had also been violently raped in adulthood with one respondent having been left for dead with severe facial injuries and burns.
Four of the respondents who had experienced childhood abuse focused upon more recent traumas, which primarily involved distressing marriage breakdowns.
For the remaining 4 respondents who did not report any childhood trauma, the traumatic events concerned a serious car accident, being raped, the death of a close friend and being left by partner whilst pregnant.

Qualitative Analysis

Thematic analysis (Boyatzis, 1997) was employed in analysing the data, which can be seen as part of the interpretive phenomenological approach (see Moustakis, 1994; Smith, Jarman and Osborn, 1999; van Manen, 1990) in that emphasis is on ‘lived experience’ and participants own views of the phenomena under investigation. Table 3 outlines the process of analysis.

Table 3. Analysis Process

Step one	Comprised producing an outline of each narrative. The process of doing this had several benefits 1) by working on the data it provided a better understanding of each narrative, 2) it helped to reduce the data thereby making it more manageable but without losing the essence or meaning of the narrative and 3) initial identification of themes, topics and patterns began to emerge. The first validity check on the analytic process involved the two authors selecting a sample of narratives and checking each other's summaries and emerging themes to see whether the 'story' had been accurately captured.
Step two	Comprised making a list of the emerging themes, reviewing them and then clustering those that fitted together into new themes.
Steps three and four	In steps 3 and 4 a coding label was applied to each new theme along with a description of the themes' contents. This process was reviewed by the two authors and themes were re-worked to provide clear and distinct codes. At this point three domains (heuristic organising categories) were identified.
Step five	To provide another validity check on the analytic process, step 5 involved checking the themes with the original narratives. This was in order to a) further define the themes including identifying, where appropriate identifiers (i.e. when the theme is to be coded) and exclusions (i.e. what is excluded from the theme), b) identify quotes to illustrate the themes; and c) see which themes could be found within each narrative (differentiation) which allows for the comparing and contrasting of themes. This iterative process (continuously switching between themes and the original narratives) ensured that any missing themes could be clearly identified. Finally, the codes were checked against 10 randomly chosen narratives by an independent rater. Final agreement was sought and codes modified accordingly.

Results

Analysis of the personal experience narratives revealed a pattern of salient themes, which featured within the data set as a whole. As each individual narrative is completely unique in terms of the experiences described, themes differed across the narratives. While the narratives draw upon past and present experiences, as well as hopes for the future, they represent individual ‘moments of being’ and by no means capture the whole picture of individual lives. What is significant about the narratives is that they capture important aspects within the person’s life, which they believe has led them to their present position and to a place where they can write about and reflect upon their traumatic experiences. From the analysis 10 themes emerged which, after being reviewed and discussed, were grouped under three broad domains, as shown overleaf in Table 4.

While it cannot be stated that the domains and themes are totally orthogonal, thematic analysis can allow subtle differences between the themes to be captured, through the development of distinct and robust codes. The domains and themes will be considered in turn with quotes added to illustrate each one. Respondents’ names have been changed to protect anonymity.

Table 4. Salient Themes Grouped into Domains

Domain and Themes	No of respondents With theme
Inner drive and motivation	
1. Survivor instinct	9
2. Taking action – for Self	15
3. Taking action – for others	6
Vehicles of Change	
4. Validating experiences	13
5. Nurturing experiences	16
6. Liberating experiences	10
7. Mastery experiences	7
8. Experiencing a sense of belonging and/or connection	8
Inner changes	
9. Being more in touch with Self	24
10. Gaining new perspectives on life	19

Inner drive and motivation

This domain concerned the presence of an underlying belief or faith in that somehow one will survive and perhaps recover from the traumatic event. It also includes a belief that somehow and at sometime one has to take action to bring about this survival and make changes towards growth and recovery.

Theme 1: Survivor instinct. Nine of the respondents within their narratives referred to or indicated some form of ‘inner drive’, ‘will’ or ‘determination’ which they felt was instrumental in enabling them to survive, live, seek meaning in their experiences and ultimately heal.

“I feel a great deal of pride that I survived the horrors of my childhood and young adulthood. I know however much I wanted to die I had a massive will to live. Why else would I be alive after being sexually abused in every way possible...why else could I be alive after being physically abused so often...I know that I nearly died at least three times. But I did live. Why else would I be alive after all the neglect - I was nothing to my mother... She wanted me dead but I lived. I lived because somewhere I was better than my abusers. I know there was a part of me that they could never touch. I was damaged on the outside but inside I was able to close myself away. Now, I am to be free, especially as I am

able to connect the different parts of my life. I am less split. This has helped to destroy my fear of my past. Instead I know I can face it. I am no longer ashamed of who I was, rather I am deeply proud of myself” (Jane)

Theme 2: Taking action – for oneself. In reflecting upon their experiences, just over half of the respondents mentioned having choices which they could act upon, as well as the realisation that they could have some control over their lives. There was also a sense of ‘fighting back’ as opposed to being passive in terms of the impact of the trauma.

“...I...went to stay in a psychiatric home for four months. There I saw many women who were trapped in the medical system of heavy medication, shock treatment and episodes of schizophrenia and self-harming. I realised that I really wanted to be well and that I could not let myself be caught up in the psychiatric system because I could be sectioned and held against my will. That thought terrified me and also highly motivated me to believe that I could be well and find a way to live a real life. I made a commitment to two sessions of therapy every week...seeing the awful injuries the women in the institution caused to themselves and the drug haze that they survived in, I understood that I had a choice not to go that way” (Cathy)

Theme 3: Taking action – for others. For several respondents the motivating factor, which brought about personal change, came about primarily from having to take action in order to provide for and/or protect one’s child or children. For Lauren and Kate having to protect their own children against abuse forced them to confront and deal with their own abusive experiences in childhood. For Cathy the need to move on in her journey was prompted by being pregnant. While Jackie wrote about wanting to be a better mother to her daughter Megan that led her into having to deal with her own unresolved issues.

“My main concern for the counselling was for Megan’s sake, I wanted to be a better mother to her and the main part of counselling was based on this. I began talking about my own childhood and that of my family, this went on for weeks and I would skim the details. It wasn’t until Claire [therapist] challenged me and said there was something that I wasn’t saying. ‘It is as if you are hiding from someone or something’ this was the key to unblocking the barriers I had put up for 36 years” (Jackie)

Additional factors mentioned within the narratives, which appear to have been integral in bringing about new insights and opportunities for change include: Feeling safe and more settled in one's life to begin facing the trauma, experiencing flashbacks, having to deal with additional traumas and engaging in repetitive self-destructive behaviours. For Karen it was reaching an all time low and wanting to break free, whilst for Martha a turning point was having a breakdown brought about by an abusive boss. She wrote:

“...it was the beginning of a long hard climb up and although devastating...I began to realise that I was only ‘ill’ because of experiences that had taken place, not because I was inadequate” (Martha)

Vehicles of change

This domain is concerned with experiences of a validating, nurturing, liberating and mastery nature identified by respondents as being important in terms of bringing about or influencing areas of positive change and personal growth. Also included are experiences, which bring about a sense of belonging or connection to others (including those of a religious and/or spiritual nature).

Theme 4: Validating experiences. Just under half of the respondents highlighted how change had occurred through experiencing genuine acceptance from others, where they felt that they could be themselves and that this was okay. For Sarah an important turning point was simply being asked about the trauma. Grace who went to see a counsellor wrote:

“what I gained from this first experience of being seen and received which I’m not sure I’d ever had previously was an opportunity to begin knowing myself and

the slow process of valuing myself. This I am sure will be a continuing growth point for me” (Grace)

For Neil it was his wife and children who made such a difference first through their acceptance and then through their love.

“I could not trust another person in the world. I was scared and I was alone. My ten feet concrete walls of hurt made sure no one ever came close enough to making me bleed pain again. I was anaesthetised. I built the blocks, which were to be the new me so well. I lived on my own. I knew emotionally I could never trust or love another person. I knew no one would ever love and accept me...I began getting visits from [church members]...I was a hard nut to crack too deep yet shallow, unreachable yet wanting to be reached...I got baptised and met my future wife for the first time...I needed my spiritual life because...it gave me a set of rules and boundaries to live my life within...It let me be myself not what I felt others wanted me to be. The process was slow with me holding back a lot. I still couldn't trust another person. However the new me was beginning to assert himself. After all why shouldn't I get to be the person I might have been...I could rise from the ashes as a strong individual who had self-esteem and self worth. I was a person who did have a contribution to make...[Whilst away with a group from the church] I was able to say to a friend 'I was abused'. I expected to be rejected but I was not. Thus another building block towards being made more or less whole was cemented into the wall that is my life...[on] our return I became romantically involved with my future wife. The biggest thing I had to disclose to her was concerning the abuse I had endured as a child. She had a young child and I had to be open about all that had happened to me. She accepted me and did not reject me. I was able to trust and love someone else, she is the keystone that had been missing in my life. This keystone is the one crucial stone without which erosion may have set in and my life would have ended a long time ago. This relationship has helped me to heal...My family have made me feel safe, secure, wanted and loved just for being me” (Neil)

Theme 5: Nurturing experiences – from one-self, others or objects. Over half of the respondents wrote about being able to give self-nurture and care in terms of recognising, seeking and meeting own needs (including safety needs), as well as being more receptive to receiving nurture and care from others. Many respondents wrote about receiving love and care from others. In addition, Mary wrote about how having her own home has also helped to bring about change.

“...Oh something else that has had a big impact is owning my own home. I brought my house about 18 months ago. It is a 3 bed mid-terrace with 3 floors (4 including the cellar) and a south facing yard at the back which produced some great sunflowers this summer! Having a home has given me a great sense of

stability and security. Not only that, but is the first home I've ever really had. It's great when I've had a tough day at work to come home, slam the front door and know that I don't have to do or be anything. It's my home and I'm safe. In a way I see it as a metaphor for my life. When I bought the property it was very run down and neglected. Every room needed total renovation. The roof leaks, the windows are rotten. So far I have installed a brand new kitchen (with my own fair hands) and am half way through fixing up the dining room. I'm planning to have an entirely new roof and extension to the top bedroom in the New Year. It's while I'm fixing up my house. I'm fixing up myself too. I really love my house!" (Mary)

Theme 6: Liberating experiences. Another important vehicle of change reported by a third of respondents was having a sense of freedom. Feeling a sense of freedom can come from several different sources including perceiving a sense of control, telling a secret, forgiveness and gaining insight and awareness. Feeling free can also be exhibited in terms of behaviours e.g. from walking hunched over to putting one's shoulders back and lifting one's head as in the case of Mary who felt totally different after disclosing what had happened to her as a child, even though she received a negative reaction from her mother and brother. For Lauren and Cathy, freedom came in the form of forgiveness. Cathy writes:

"Over some long time I began to change and to make different choices. I felt so burdened by the hatred and drive for revenge that I had been carrying around in me, for such a long time. I began to realise that the price I was paying for my desire to hurt back was too high. I wanted to free myself, to move on. I needed to let go of my commitment to revenge... I had learned from many mistakes, that I needed to forgive myself thoroughly for all the ways I had abused myself. I felt for many years that there was no-one else who deserved to be forgiven, that I was the one who had been so devastatingly wronged. I felt justified in this belief, yet over time I realised that it was not enough for me to forgive myself and treat myself with compassion. I longed for freedom in my heart but I was still very stuck. I need to be free, for myself, for my future... I was unable to grow unless I did a huge turn around. I gradually came to understand that if I really wanted to be free in my heart, I need to forgive my parents and...everyone else who had failed me. This was and continues to be the most substantial lesson of my life. I learnt that I had a right to my freedom and I could give myself what I longed for, by forgiving. I discovered that by forgiving those who had wronged me that I enabled myself to grieve fully and finish with grief for all the losses. I enabled myself to see beyond me, and my experience to discover joy and lightness. I enabled myself to blossom like a flower and discover my true power. Such is the paradox. I realise that I came to this discovery in my own timing and when I was able to. Then I took the steps to forgive... The most important part was for

me to feel forgiveness in my heart. This has been truly healing in the depth of my being. No other experience has been so life changing for me...I want to be clear that my experience of forgiveness has nothing to do with any religious or moral dictate. For me, forgiveness is a psychological tool to claim my right to freedom” (Cathy)

Theme 7: Mastery experiences. Whilst some respondents such as Cathy wrote about the powerful impact that liberating experiences had, others wrote about how change came about through gaining a sense of accomplishment and achievement. For Susan it was getting top marks in her maths exam.

“I went back to college to try to gain my G.C.S.E. in Maths. Due to ill treatment in the past I started this course with very low self-esteem and low self-confidence. I also failed ‘O’ Level Maths in [the past] due to the abuse from my parents. At the end of the course I got 99% in one of the Exams, coming top of the entire College. I am also now doing A/S level Maths and hope to gain a degree eventually. This to me is a form of fighting against my parents, my ex-husband and plenty of others who have called me names over the years...I now feel like I can take on the World and win and no amount of being put down or bullying is going to affect me anymore!” (Susan)

While for Francis it was going through with the prosecution of her abuser.

“I felt that I had, at last, taken back the power that my abuser had stolen from me as a child, by naming him and telling the Police what he had done... The physical act of prosecution and going to court has given me more strength than I ever thought could although I have never been so frightened in all my life. I made myself look at him in court and although in tears at doing so, I was able to replace the old image of him with a new one. I am now growing in strength and although I know I have a long way to go, I am confident that my distorted opinion of men in general will be changed and I can enjoy my right to be female” (Francis)

Theme 8 Experiencing a sense of belonging and/or connection. In eight of the narratives respondents wrote about having a sense of belonging or connection with someone or something. For example, Mary wrote about the importance of feeling understood by her partner, while Jack wrote about

having a ‘guardian angel’. What appears important for Kate is her faith and connection with God.

“I was nearly six years old at the time of ‘Mortal Danger’ [title of narrative depicting the near sinking of the ship respondent was on], which I have included because of the assurance I had at the time of God’s existence and benevolence towards me. He made Himself known to me, despite my youth and contrary to the facts of the moment with regard to the actual danger in which we found ourselves. It was a source of surprise to me at the time, that I was so sure we would be fine and I knew the difference between this and any other fine detail of assurance - such as we would go to be with Him in heaven when we died; or that we were going to die now, but then be safe in heaven with Him. The inescapable fact that he had communicated His intention to me, and brought it to pass, has acted as an anchor to my faith over very many years, especially as more and more confusion piled in to the void left by the lack of positive nurture and direction in my other circumstances. Somehow (I now realise), I have always known how to pray and that while it (the prayer for whatever), was the instinctive cry of my heart, I was always heard and very often answered in a metaphysically tangible way. This knowing that I can ‘know’ what He wants me to know is a vital part of my stability now. I also recognise that His presence of the power of Life itself, in my spirit and soul has had a substantially healing effect and enabled me to continue into the future, many times” (Kate)

Inner changes

This domain relates to increased insight and understanding, recognition of changes and the processing of experiences brought about by vehicles of change. Salient themes under this heading concern being more in touch with Self and gaining new perspectives on life.

Theme 9: Being more in touch with Self. This broad theme relates to increased self-awareness and covers all descriptions of positive change relating to Self and one’s relationships. It also includes being able to feel, express and process feelings, the recognition of inner strengths, as well as recognition of further changes needed in one’s life. As might be expected this theme was clearly evident in virtually all the narratives.

“[After praying with two Christian friends]...I began to have a sense of personal identity that I couldn't really remember from my era in my past. I also felt that unlike 'Humpty Dumpty' every part of me had been scooped up again and replaced into my real, whole shell and put back on the 'wall'. By this I had deduced that I'd been smashed to the ground until then”. (Kate)

“[The car accident] brought many positive changes in my relationships with those around me, because I had to learn to trust them to look after me, and had learnt how much they meant to me” (Roger)

“At present I feel like I am entering a feeling stage, where I am remembering how I felt, both physically and emotionally as a child being abused. It is a difficult time and I have to keep reassuring myself that the things I am experiencing are just feelings...I feel turbulent at the moment as a lot of anger is surfacing, though flashbacks have eased off. Once again I feel my strength increasing as I rise out of the pit again” (Sarah)

“There are times when I wish I could return to a time of less self-awareness, a kind of blissful ignorance but the gain perhaps of increased self awareness is an increase in the depth of feeling good/bad, happy/sad etc which I wouldn't now be without” (Grace)

“...I can't carry on that struggle anymore, I recognise that I need a life, I need to be me, I need to feel, I need to be real, I need to know the truth about myself...there are still a lot of areas in my life that do need change. My whole lifestyle, all my life has been chaos. I have a long way to go before I am no longer sick, but I do feel a lot better” (Karen)

Theme 10: Gaining new perspectives on life. Two thirds of respondents also wrote about changes in their worldview, which included simply seeing one's life differently, having new priorities in life, recognition and acceptance of one's past, living more in the present and finding meaning in one's life.

“I rejoice in my life as it is now and yet I know that who I am now, is inextricably linked with the experience of the abuse. My deepest joy is that I have been able to transform the legacy of the abused survivor, into the means of discovering who I am beyond this legacy. Therefore I do not need to wish, that it had never happened. (Cathy).

“It has been a time of great contrasts - anguish and despair followed by real joy and confidence. I feel as if I have crossed a bridge and now on the other side, but still finding my feet...I know though that life is change and one of the ways I have changed is a much greater sense of living in the present, being present now and accepting that everything changes and ultimately dies” (Karen)

Several respondents also talked about awareness of ongoing changes and appropriate ownership of responsibility.

“I don’t think the changes are ‘over’ - I am still changing. In some ways some parts of me have reverted to how they were before. I have less of an imperative to ‘do it all now’, a feeling that was very strong immediately after the accident. Some of the changes that came about during the first couple of years were a little scary for me and those around me I think... I have eased off some of the pressure on myself now, and it is only in retrospect that I can see that although I may not be driven so strongly by those acute feelings of mortality, they did propel me a long way from where I was and in a good direction on the whole I think. Not all the changes are for the good, I guess, but I wouldn’t swap my life now for where I was before” (Roger)

“Whilst I have found peace with Henry, my adult children, with whom I had had a very intense relationship, are unwilling/unable to accept that my love for Henry poses no threat to my love for them. Their jealousy and resentment has led to a complete breakdown in their relationship with me. If I were a child I would stamp my feet and scream ‘not fair!’ It is a sadness that they appear to begrudge me my newfound happiness but I cannot make them do anything or be anything they do not want. Perhaps it is a sign of my personal growth that I accept they must live their life as they choose, I am not responsible for them or their decisions. It is not my fault. I have learned to appreciate what I have i.e., a loving husband and three stepchildren with whom I have a warm and affectionate relationship. I have developed a more philosophical and patient approach to life. That aspect of my personality wobbles a bit when I am tired or worried BUT always I bring myself back to the fundamental belief that it would be foolish indeed to yearn for something which may never come about and so diminish or sacrifice what I do have” (Maria)

While ‘making sense’ of one’s traumatic experiences feature implicitly throughout the narratives, a few respondents explicitly wrote about ‘making sense of ‘ or ‘trying to make sense of’ their experiences.

“...I went nuts at Luke [boyfriend]... he started to punch me, a lot, I got hold of a roasting tin and whacked him round the head with it, we really physically hurt each other, and I’ve got to admit, I enjoyed hitting him. I felt like really hitting him. I called the Police, I had a massive black eye, Luke was in shock, it was all nuts. We parted a week later..I couldn’t cope with him no more. I was in shock, numb. This was the life-changing occurrence I was building up too. It was just too bizarre for me. Well...I have not gone down with depression this time. I have had a few moments of melancholy but I have now stopped to think, and take a good look at my life...And now I’m learning the meaning of the word reflection. I’m seeing how my life has gone round in circles of struggles, and come back to the same point time and time again (pathological behaviour?). I want to break free of that circle, perhaps I already have, because I’ve started to realise what has been going on with me. I know that what has happened to me in

teens to adulthood is because of what I experienced in childhood... What has happened has prompted me to read psychology...and how and why addiction to substances and behaviour patterns occurs. I am starting to understand, to really see what has been going on, not just with me, but with members of my family...It has been a very difficult thing to make sense of. Only I cannot stand to see the level of suffering, and I am now determined to aim towards positive change” (Anne)

Discussion

Given the uniqueness of the personal experience narratives, 10 salient themes emerged which we believe reflect the stories being told. Some respondents wrote much about their lives detailing where and how they believed change and growth had occurred, others wrote less. While only one or two of the themes were present in several of the shorter narratives what was of significance is that those themes were of importance to those individuals, reflecting their lived experiences, turning points and their perception of themselves. Riessman (1992) refers to stories as a ‘kind of cultural envelope into which we pour our experiences and signify its importance [allowing] us to make connections and thus meaning by linking past and present, self and society’ (p.232). However, one cannot assume that those experiences not mentioned by respondents (such as those we have grouped under vehicles of change) had not occurred or if occurred did not have an influencing effect on their lives. The narratives can only capture a snapshot of respondents’ lives along with the reflections that respondents made at the time of writing. Our aim throughout was to reflect as accurately as possible the contents of the narratives and in doing so look at areas of positive change and personal growth. Whether the themes and our organisation of them represents a coherent account or uncover new insights is left for the reader to judge.

The analysis of the personal experience narratives revealed many examples of positive change and personal growth, as well as revealing how such changes may have come about. While areas of inner change varied for each respondent, changes fell into two main themes reflecting Tedeschi et al (1998) changes in perception of Self and changes within one's philosophy of life. Respondents wrote about being aware and more connected in terms of who they were as individuals. Specific areas concerned greater awareness of inner strengths along with the ability to feel, express and process feelings. For many respondents who had experienced childhood trauma, their narratives reflected a search for identity, to know who they are. In these cases one aspect of growth can be seen as the finding of oneself. As illustrated by Lauren who wrote: *"most change is in knowing who I am and what I want"*. The search for Self and identity often emerges within narratives (Freeman, 1993) as well as being an integral part of healing for those who have experienced childhood trauma such as child sexual abuse (Woodward, 1999; Woodward and Fortune, 1999). One reason why the search for one's identity is so important, is that if a crisis occurs such as childhood trauma before identity is fully developed, it is likely to have a longer lasting impact upon our sense of Self. This is because identity provides a means by which the experience of who we are can be integrated (Calhoun and Tedeschi, 1999). The other main area of change noted within the narratives was the gaining of new perspectives on life which included changes in priorities, greater recognition and acceptance of the past and living more in the present. Being aware of the changes that had occurred, as well as being able to find meaning in one's experiences further contributed to a more positive outlook on life.

Changes in one's relationships was not categorised as a separate theme and although several respondents commented upon the love and support they were receiving from partners, relatively few mentioned actual positive changes in their existing relationships. This finding may reflect that less than half the respondents were involved in a relationship at the time of writing. Furthermore, for those who wrote about traumatic events in adulthood, in the majority of cases the trauma itself involved their relationship. Roger, who was involved in a serious car accident, commented that he was aware that he had not really focused upon his relationship. He writes: *"I realised that I had talked almost entirely about myself, and little about my relationships with others. This made me wonder whether I should bring some new changes to my outer, as well as inner life"*.

For the respondents who experienced childhood trauma what appeared to be important was meeting someone who they felt was supportive, and where they could be themselves without fear of rejection. The literature suggests that self-disclosure and emotional expressiveness may help to improve communication and intimacy (Dakok and Taylor, 1990). It may be the case for those respondents who are in supportive relationships that the quality of their relationship is strengthened through being able to work through their traumatic experiences in an environment, which offers nurture, validation and support. While the ability to express feelings and disclose important information has been shown to be beneficial (see Pennebaker, 1995; Pennebaker, Kiedidt-Glaser and Glaser, 1988), it has also been found that expressiveness and openness may not always be helpful in all situations and especially in areas of rape and childhood sexual abuse. While some respondents such as Neil wrote about how they were able to put their trust in

others, Mary and Karen commented that they were now more wary of others that they did not know. Tedeschi, Park and Calhoun (1998) suggest that may have been learnt is better recognition of who can be safely trusted.

In exploring areas of positive change within the narratives, additional themes emerged which appeared to have influenced or brought about areas of change and growth. The first domain (inner drive and motivation) reflects the idea that for some respondents there was an underlying belief or faith that they would survive their traumatic experiences. We identified this as the 'survivor instinct'. Some form of 'inner drive' that they felt was instrumental in enabling them to survive their experiences, adjust, and move towards recovery. While the 'survivor instinct' was only evident in approximately a third of the narratives, many more respondents wrote about how they had been equally instrumental in bringing about change. For some taking action initially came from the need to protect one's children, for others there was a variety of 'triggering factors' such as reaching an all time low and recognising the need to break free and change. Whatever the initial experience, ultimately respondents took action regardless of how long it may have taken to do so.

The initial stages of change were primarily achieved through taking some control over their lives and acting upon choices that would ultimately help lead them towards positive change and growth. Rogers (1961) 'actualising tendency' is one way which may also account for our findings. Rogers argued that human beings are driven towards constructive growth. Many of the narratives are wonderfully illustrative of this inner drive towards change and growth. In addition,

respondents wrote about those experiences, which they felt brought about fundamental changes in their lives. It was clear from the narratives that many respondents had undergone significant personal development over the years. Seventeen respondents mentioned that they had experienced some form of counselling/ psychotherapy at different times in their lives. It was clear that this was not the case for two respondents, while therapy was not mentioned by the remaining ten. Therapy, in itself however clearly was not the only factor bringing about change. What did appear to be important were many of the qualities, which emulate the therapeutic environment, such as acceptance, positive regard from others and ‘empathic understanding’ (Rogers, 1957).

Vehicles of Change, the second domain reflects the key themes that respondents highlighted as being important to them. What emerged as being of significance were experiences of a validating, nurturing, liberating and mastery nature, along with experiences which brought about a sense of belonging or connection to others. Also of importance to respondents was being able to live more authentically (Deurzen-Smith, 1998) - to be themselves. Several of these themes overlap with Maslow’s hierarchy of needs particularly the needs for safety, love and belonging, esteem and self-actualisation (Maslow, 1993).

Maslow (1993) suggests that to achieve self-actualisation small changes need to occur over time. It is apparent from the narratives that positive change and growth has occurred to some degree for all respondents. Within the humanistic approach, there is the notion of the self-actualised or fully functioning person. Such individuals are “self-directed, creative, independent, have accurate views of

themselves and other people, are willing to try and understand other people's points of view and are open to new experiences" (Joseph, 2001, p.134). While, there is the recognition by many respondents of the need for additional changes, some could indeed be described as 'fully functioning' people - a position not easily attained. According to O'Leary and Ickovics (1995) there are three possible outcomes following what they refer to as a challenge: survival, recovery or thriving. Those who merely survive never regain their previous level of functioning. Those who recover regain homeostasis and return to their previous level of functioning. Whereas those who thrive move beyond the original level of psychosocial functioning, flourish and grow. It is very clear from the narratives that respondents were generally moving past recovery to thriving, growth and transformation.

One of the questions arising from this research concerns how we can best help clients achieve positive change processes? It was clear from a number of narratives that such change and growth only occurred after many years. For example, Caroline commented that it had taken her fifty years to get to the point of finally knowing what she now needs, in order to complete her recovery and make the transformation. For Cathy "the journey to freedom" had taken twelve years for which she writes "I make no judgement on this. It has taken as long as I needed it to take". Jung writes about an 'inner wisdom for healing' which nicely reflects those respondents who have been kind enough to share aspects of their lives for this study.

Perhaps as therapists we need to ensure that we are client-centred in our approach: that we do only ‘walk along side’ clients as they undertake their existential journeys. Maybe we need to worry less about our actual therapeutic techniques and concentrate more on ensuring that we provide what Rogers refers to as the ‘necessary and sufficient conditions’, along with the recognition that change, progress and growth is the result of “a gradual acceptance of oneself in the ebb and flow of everyday life – an acceptance that recognises both pain and resilience” (Woodward and Fortune, 1999, p.138). What was also important for several respondents, was the recognition of what they themselves, had achieved to bring about growth. Perhaps greater attention should be given to helping clients harness their own ‘inner wisdom for healing’ as a means to facilitating posttraumatic growth.

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Chapter IV

Potential Benefits of the Research Process for Participants and the Researcher

The aim of this paper is to 1) provide an overview of the research process and how the thesis came about, 2) to highlight methodological issues by drawing upon the therapeutic use of story telling and 3) in thinking about clinical implications explore the concept of vicarious posttraumatic growth. A central thread that runs through this paper concerns my own personal reflections as to the experience of doing research and the potential benefits (as well as risks) that the research process might have for participants as well as the researcher. Therefore a further aim of the paper is to go ‘beyond methodology’ (Fonow and Cook, 1991) in the sense that it aims to be a reflexive review of a research process.

The notion of reflexivity can mean several things. It can mean the tendency to reflect upon, examine critically, and explore analytically the nature of the research process. It can also mean being open and honest about oneself in relation to one’s research and in particular not having to be ‘wholly neutral, disinterested or value free’ (Henwood and Pigeon, 1993). The value of addressing and making visible one’s subjectivity has been widely recognised within feminist epistemologies, as well as being seen as an essential part of the research process by advocates of the interpretative tradition. However, the idea of ‘bringing oneself into the research process’ is a far cry from positivism and the notion of objectivity. In what could be described as a bridging position is the concept of ‘critical subjectivity’ (Reason, 1994). This is ‘an acceptance of our involvement with those we research, but an involvement that is ‘critical, self-aware, discriminating and informed’ (p.11). West (1998) in a paper exploring critical subjectivity and the use of self in counselling research highlights that both human inquiry and heuristic

research makes ‘use of the researcher’s involvement both as a source of data and as a way of making sense of the research’ (p.228).

Trying to make sense and find meaning, represent core components of any qualitative research. Such themes can be found both in the words of participants, as well as the desires of the researcher when contemplating what to do with such ‘thick’ (Denzin, 1989) and rich descriptions at his or her disposal. A further core element of any research, I would argue, is the impact of the research process both for the participants and the researcher. Despite this aspect of the research process being recognised within feminist research, (in addition to ethics and the necessary guard against doing harm), a more detailed account of the actual research process in terms of its impact, whether negative or positive, is often not documented. One of my aims therefore was to explore the process of actually doing the research and trying to ascertain what this might mean both for my participants and myself. It is this aspect of the research process, which I intend to be the main focus of this paper. In doing so I wish to explore two key areas central to my research: the therapeutic use of story telling; and vicarious posttraumatic growth. My hope is that this will provide a somewhat different reflective review in terms of the methodological and clinical issues related to the research. However, I will also include additional research issues as they arise.

An overview of the research process

In having set the scene, I will now describe the research process starting at the beginning. I have had a strong interest in trauma and its impact for a number of

years. As part of my clinical training I have undertaken research into the processing of trauma, which firstly involved a study based upon Posttraumatic Stress Disorder (PTSD) and the treatment Eye Movement Desensitisation and Reprocessing (EMDR). However, while I regard this work as valuable especially in terms of exploring the efficacy of treatments for the alleviation of the symptoms of trauma, I have found that I became strongly drawn to the more salutogenic side of trauma. In other words looking at people's strengths and the adaptive ways that they have coped and survived trauma, as opposed to the more maladaptive and negative effects that trauma brings. With this desire I conducted an additional study in the area of posttraumatic growth (PTG) (Calhoun, Park and Tedeschi, 1998). West (1998) highlights that one of the most important demands placed upon the heuristic researcher is a passionate need to know about the research question or themes, otherwise the research will not happen or get completed. This statement caught my eye, as I am aware that although I would not necessarily class myself as a heuristic researcher (more of an interpretive phenomenological person with a passion for capturing and analysing lived experience!) I have found it much easier staying motivated by the PTG research. It also helped that this study builds upon some of my earlier research (see Woodward, 1999). While, the necessity of a strict deadline ensured that the research was completed, regardless of interest or motivation, factors such as interest and ownership play an essential role within the research process. Certainly I was pleased to do the PTSD/EMDR study but I further struggled in that it was not my original idea. It afforded for me the attraction of trauma, treatment and the opportunity to familiarise myself again with quantitative research (after having

previously conducted a qualitative PhD). However, I now know that when it comes to methodological preference my heart is in qualitative research.

The decision to conduct the PTG study after having put most of the time and effort into the PTSD/EDMR study meant that another pragmatic decision had to be made when considering the research; that is, the time one has available. Having conducted previous research that had drawn upon over a thousand letters in the form of life stories (see Wattam and Woodward, 1996), I found written documents in the form of personal experience narratives to be a very rich source of data. In addition, this perfectly suited the research process, as I did not have the time to collect and transcribe interview accounts. Moreover, I wanted participants to tell their story their own way with little influence from the researcher. This work had also led to my interest in the therapeutic use of story telling. I therefore set about collecting stories of self-perceived trauma by advertising for people to write in to me if they wanted to participate in the study. The stories mostly focus on experiences of childhood sexual abuse and were written by both men and women with different experiences and stories to tell.

Exploring the therapeutic use of story telling.

Within the therapeutic literature, some recent recognition has been given to the therapeutic use of story telling (e.g. Goldsteingberg and Bутtenheim, 1993; Laird, 1988; Dwivedi, 1997; Wiersma, 1992). Here it is felt that by 'storifying a life' we can bring order to random happenings and make sense out of our experiences by reconstructing and reinterpreting them. Thus instead of trying to recover an

individual's past, the positive effect of psychotherapy might have more to do with reconstructing one's history (Wiersma (1992). This implies that a story is not static and thus can change, and in that change lies its therapeutic potential. A narrative approach to understanding human life can be seen as 'a broad, coherent and creative framework for psychotherapeutic theory and practice' (Dwiveldi, 1997), and has been used by a number of psychotherapists within their clinical practice (e.g., Mair, 1989; Viney, 1993). The most fundamental clinical application of story and metaphor is through enabling the person (or family or group) to 'tell their story' in order to help them discover meaningful sequences and gain insights and coherence. Moreover, whether a story is written or spoken, allowing a story to be told has additional benefits, in that for disempowered individuals or groups the opportunity to find a voice and tell a story can be especially beneficial and has the potential to lead to transformations in people's everyday lives (e.g., Plummer, 1995; Roberts, 1994; Woodward and Fortune, 1999).

Given my interest in the therapeutic use of story telling I was keen to explore not only the contents of the narratives but also participants' impressions of telling their story. Participants' reflections on writing were captured by asking two questions: 1) how did you find writing the letter? (e.g., was it easy, difficult, upsetting, good, uplifting, insightful etc); and 2) were you aware of any surprises or anything new about yourself when re-reading the letter? If so what form did this take?

I found myself incredibly pleased and excited by the comments from participants, which were largely extremely positive. For example one participant wrote

“I was very enthusiastic about writing. I took a lot of time though this was easy to do. It seemed to naturally form its structure. I cried with joy as I acknowledge all the change in me and the beauty of discovering the truth...this is a testament to my commitment to be well and discover the meaning of my life” (Jane)

There was *the sense* that not only had I not done harm (a fear of mine when conducting any research, especially research into trauma) but that the research process in itself may have been of some benefit. In addition I was also aware of not only sensing benefits within participants but also within myself as the privileged researcher. By this I do not merely mean professional gain in that this research will provide part of my qualification as a clinical psychologist. However, before I explore the idea of vicarious posttraumatic growth, I would like to highlight a few research issues relevant to telling one's story. My original intention was to include a section on the benefits of writing taken from my study. However, this aspect to the research will now be written up as a separate paper for dissemination due to word length constraints. I will now focus upon the ethical and research issues that can arise when using life story methodology.

Potential risks in telling one's story

In exploring the impact of the research process on participants it is important to be aware of any potential risks as well as to take seriously the responsibilities of the researcher to the researched. For me, as the researcher I am aware of having the following responsibilities to my participants: 1) being alert to the impact of being

involved in the research, whether the experiences are good, bad or a combination of the two; 2) thinking through how the data is to be used and how I am going to represent not only the participants but the stories that they tell; and 3) being aware of the power imbalance that exists between the researcher and the researched. This power imbalance is shown in respondents having the power and control over what they chose to write about, and with me having the control and power in how I interpret and represent their written words (see Woodward, 2000). In having previously adopted a feminist epistemological perspective with an emphasis on emancipatory research, it was important for me that participants were able to tell their story in their own way and that the space was created in which their stories would be heard and their experiences validated. Research issues can comprise a number of factors including epistemological, methodological, ethical and practical issues. In terms of practical issues, it is usual in conducting research to come up against a number of constraints. For me this included my own resources in being available for participants, the time I had available to conduct the research and additional constraints such as word length for individual papers.

In being aware of the potential impact of writing, I felt that the participants who were most likely to write in would also be more likely to have already done a fair amount of personal work on themselves as well as having in place a supportive social or family network. This was based upon the available literature, although I also recognise that distress and growth can co-exist (Calhoun and Tedeschi, 1999). My hope from the beginning of doing the study was that participants would be more likely to find the process of writing about positive changes ultimately easier, validating and possibly uplifting: in essence therapeutic. Given

that participants were primarily recruited through a newsletter for the charity the National Association for People Abused in Childhood (NAPAC) there was the available resource of a postal service run by an experienced counsellor. It was very important for me that I kept firm boundaries between being a researcher and being a psychologist in clinical training. Although as stated I hoped that the process of writing would be therapeutic this was an indirect aim. I personally was not offering any therapy. In only two cases did I suggest to participants that they may also like to write in to NAPAC's postal service. One participant stated that they were telling their story for the first time, and although they may only be looking to have their story heard, it can also be a step towards wanting to receive help. A second participant wrote to me not in relation to the research but directly for help and therefore I referred her on. I did however, personally respond to all but one letter (due to not having an address) to acknowledge and thank the participants for writing. This led in several instances to a limited correspondence, whereby six participants chose to write more than one letter.

In terms of representing participants and their words (along with recognition of the power and control I had over the interpretation of the words), I had written in the advert that every precaution would be taken to ensure participants' anonymity and confidentiality. This however can be difficult to guarantee, especially if respondents' words are to be kept largely intact (except for the odd change of identifiers). Many participants reported that they did not mind their name or details being used. Given the constraint of word length I knew that I would be reducing participants' words down to salient themes, except for a few relatively short quotes. I certainly was not going to be able to reproduce much of the

original words of respondents. In addition, given constraints of time I also would not be in the position of being able to go back to participants to check out my interpretations of their words. Therefore, despite having put in place reliability and validity checks in terms of coding the data, it is left to the participants and any readers of the papers related to this research to judge the accuracy of how respondents and their words were represented. My hope can only be that I have been able to do justice to the words of the participants.

The last section of this paper focuses upon the impact on me, as the researcher, of having conducted the research. This is explored by looking at the concept of vicarious posttraumatic growth.

Exploring Vicarious Posttraumatic Growth

It has been recognised that therapists can be negatively affected when working with clients who have experienced traumatic events (McDaniel, Hepworth and Doherty, 1997; Bennett-Baker, 1999; Everett, 1997; Valent, 1995). Secondary or Vicarious posttraumatic stress can include, for example, the clinician experiencing a range of distressing emotions in response to hearing a client's description of a traumatic event. A new body of literature has begun to focus upon the notion that not only might it be possible to be negatively affected by stories of trauma, there may also be positive effects of working with clients who have experienced post traumatic growth. In their book 'Facilitating Posttraumatic Growth', Calhoun and Tedeschi (1999) highlight the different areas in which vicarious posttraumatic growth might be present. These include: 1) simply being inspired through hearing

client's accounts of heroic struggles and stories of survival, 2) in listening to the traumatic experiences of clients, therapists may find themselves thinking about their own life priorities and making some conscious choices about what is important to them; and 3) experiencing a stronger connection to others, along the same lines as clients may do, given that a direct struggle with crisis can lead to a stronger bond to other people.

A further suggestion is that the combination of the therapist's own heightened existential awareness, along with an enhanced sense of connection with people can lead some therapists to become socially active participants in life.

I have found myself drawn by the notion of vicarious posttraumatic growth as it provides an explanation for some of the ways in which the research has had an impact upon me. Certainly I have felt, at times, incredibly in awe of and wonderfully inspired by the participants and their stories. I am also very aware of how different I have felt when reading about experiences of posttraumatic growth as opposed to working face to face with participants who are suffering with posttraumatic stress disorder. Here I found that, at times, I was left with strong traumatic images (even though I was not treating or even seeking from participants their traumatic stories. However, there were occasions when the participant did mention the traumatic incident). When reading the stories involving posttraumatic growth or as in some instances what was described as 'moments of enlightenment', I found myself, at times, saying '*YES*' and feeling quite emotional due to strong positive emotions of joy, excitement and happiness.

I further feel that as a consequence of this research, one theme that has emerged for me is the realisation that I desperately need to create more 'space' in my life for me and to pay greater attention to my own needs. Many of the participants who wrote about personal growth also identified how they have learnt to give or receive nurture and self-care as well as being receptive to the nurture and care from others. This change can be seen as quite a transformation as for many participants it is in contrast to previous patterns involving self-destructive behaviours. For me I feel that in having been studying and/or training for the last ten years I am now searching for something else. Of course other factors in addition to conducting the research will have had an influence on my present perspective, such as having taken this path in life, age and changes within my relationship. However, seeing personal growth in others has led to the conclusion that enough of my energy has been given to the area of professional growth and development and perhaps not enough has been given directly to areas of personal growth and development. In line with this realisation, I have also found that I am beginning to pay greater attention to the things that I believe I need and want from my life, as well as appreciating much more my relationship with my partner.

Finally, having done research as well as having worked in the area of trauma for some time, I am acutely aware of having been socially active through voluntary work and being involved in the setting up and being Chair of a new charity The National Organisation for People Abused in Childhood (NAPAC). However, given my own areas of increased insight and awareness I will be letting go of this extra curricular activity in order to create more 'space' for me.

Endings, thoughts and possibilities

I would like to conclude this paper by exploring briefly the possibilities for change when moving from notions of individual transformations to social transformations. Throughout the research process I became aware that not only was there the potential for participants, as well as myself, to benefit from the research process but that the research had already migrated into the wider social domain. Of course one is hopeful that the research will be published and thus disseminated to a wider audience, however, I was surprised at how a wider audience was already being reached by people telling their stories. To begin with a few participants had previously written books about their experiences, and several others had also gone 'public' with their story within local and national newspapers. A further finding was that from writing and having their story heard and validated several participants wrote to enquire whether they could go on and write something for the charity (NAPAC) or send in poems to be published in the newsletter. I also feel that having advertised the study within the charity's newsletter, which although not a NAPAC project, gave people the opportunity to contribute and feel part of a larger concern. Finally, there was some sense that the positive focus of the research seemed particularly important for some respondents who may have been looking for a more hopeful perspective on what it means for some individuals to have experienced traumatic experiences. I will end on the words of one participant

"I feel enthusiastic about the positive approach you are taking, of focusing on what have been the creative driving forces, for making sense of what has happened and for change" (Cathy)

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Appendix 1

Ethical Approval from Warwickshire Research
Ethics Committee

4th June 1999

Westgate House
Market Street
Warwick CV34 4DE

WARWICKSHIRE RESEARCH ETHICS COMMITTEE

Telephone: 01926 493491
Facsimile: 01926 495074

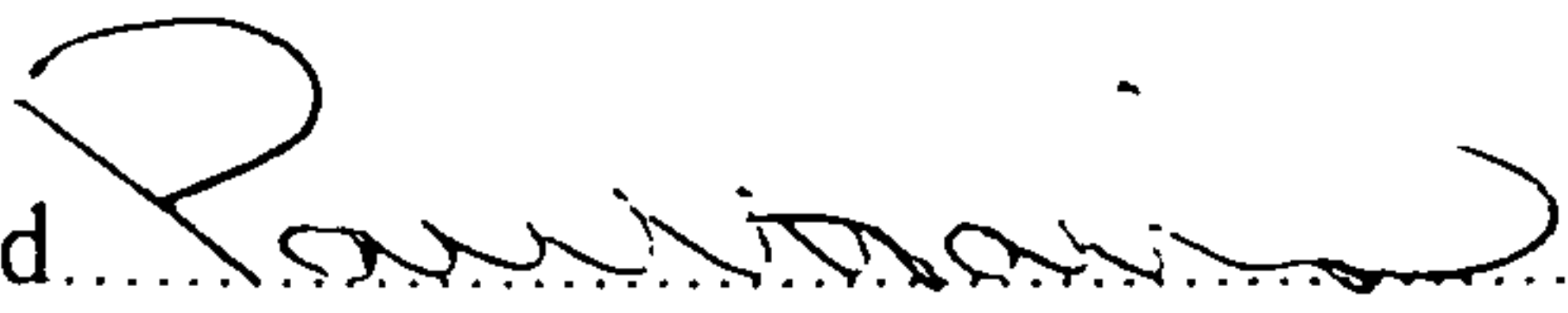
The following LREC clinical trial protocol has been examined from an ethical viewpoint and the decision of the Committee is as follows:

Chairman Mrs J Gove OBE
Chief Executive Mr A.M. McKeever

		Documentation Reviewed as itemised in ICH guidelines	
1.	* Approved	Protocol	<input checked="" type="checkbox"/>
		Patient Information Form/ Consent Form	<input checked="" type="checkbox"/>
2.	Approved subject to amendments listed below	Indemnity (signed) CTX	<input checked="" type="checkbox"/> <input type="checkbox"/>
		Protocol Amendments	<input type="checkbox"/>
3.	Rejected for reasons listed below		
4.	Approved by Chairman's Action		

Ethical Committee Minute Number 348/99 Dated 26.5.99

Protocol Title and Reference Number
RE 407 EYE MOVEMENTS AND MEMORIES
(Dr. K. Garvey)

Signed..........Committee Chairman

Dated.....4/6/99.....

This approval is subject to the following standard conditions :

1. the study must begin within one year;
2. the researcher must seek the Committee's approval in advance of any proposed deviations from the original protocol;
3. any unusual or unexpected results which raise questions about the safety of the study must be reported to the Committee.
4. progress reports must be submitted to the Committee annually; and
5. a summary of the study's findings must be submitted to the Committee upon its completion.

Appendix 2

Information Sheet for Mental Health Professionals

Research Project : Investigating Eye Movements and Personal Memories

Information for Mental Health Professionals

Dr. Kay Garvey and Dr. Gary Willington (Clinical Psychologists) are conducting a research study exploring the effects of eye movements on personal memories. One of the subject groups for the study are adults who are suffering from post traumatic stress disorder (PTSD) who are presently receiving treatment from the mental health services. Your assistance in recruiting suitable participants for the study would be very much appreciated.

Please find attached a participant information sheet, which can be given to potential participants. Potential participants do have to meet certain criteria before they can be accepted on to the study. The criteria for inclusion are as follows (please tick to indicate suitability for the study) :

Name and date of birth of potential participant :

Eligibility criteria

Fulfil criteria (Please tick)

Aged 18 or over

Currently receiving mental health services

Suffering from PTSD
(as defined by DSM IV)

No psychiatric history preceding
the onset of the PTSD

No evidence of severe mental illness

Risk category : CPA 3

If you think that you may have a suitable participant for the study, please give an information leaflet to them. If they are interested in participating in the study please send their name, address, telephone number and a copy of this sheet back to Dr. Kay Garvey, who will then contact the potential participant directly. You will be informed of your patient's participation in the study. If you have any questions or would wish to discuss any aspect of the study, please contact Kay Garvey directly.

Thank you for your assistance in the study. The findings will be presented in the trust at the end of the study.

Appendix 3

Participant Information Leaflet (Clinical Group)

Investigation into the effects of Eye Movements on Memories

Participant Information Leaflet (Clinical group)

Background

Following a significant trauma, it is common for individuals to suffer from intrusive memories about the trauma. A significant number of individuals go on to develop symptoms of Post Traumatic Stress Disorder (PTSD). A recently developed psychological treatment to alleviate PTSD symptoms uses eye movements as one of its components. Two psychologists (Dr. Kay Garvey and Dr. Gary Willington) working clinically in Warwickshire are interested in finding out what effects eye movements may have on individual memories. Hence, a research programme has been set up at Coventry University under the direction of Dr. Kay Garvey to explore this area.

Whilst it is not envisaged that participating in the investigation will provide you with any direct therapeutic benefits, it is hoped that the information gathered will help in the understanding and development of new and effective treatments for PTSD.

Procedure

Each participant will be invited to meet one of the researchers in the study to discuss further the nature of the investigation and to ask any questions you may have about the study. The researcher will also check the information provided by to ensure accuracy. If you then wish to participate in the study you will be asked to read and sign a consent form and your G.P. will be informed of your intended participation.

The study will actually take place at Coventry University and a remuneration fee for inconvenience of £10.00 plus travel expenses will be paid to all participants. The research session will take two to three hours and will take place in either a morning, afternoon or early evening. Every effort will be made to make the session as pleasant and interesting as possible.

During the investigation.

You will be asked to provide information about yourself including brief details of the incident(s) triggering the onset of the PTSD. Any memories relating to the onset of the PTSD will **not** be used in the investigation. In addition you will be asked to complete some questionnaires concerning your present emotional and mental well-being. During the course of the investigation, memories of events from your own life (chosen by yourself) will be used in the investigation. All this information will be treated in the strictest confidence and will be coded such that it is anonymous. It will be stored securely at Coventry university.

You will be able to withdraw at any time during the study. If, in the unlikely event that you feel distressed or uncomfortable during the study the researcher will check with you as to whether you wish to continue. There will be no pressure to complete the study and your participation or otherwise will not effect the care and attention you receive from your doctors or any other health professionals. Your doctor and mental health professional(s) will be informed of your participation in the study.

Still Interested ?

If you would like to meet with one of the researchers to discuss the study further, please inform who will pass on your name, address and telephone number to Dr. Kay Garvey. Dr. Garvey will then contact you directly to arrange a convenient appointment to meet you.

Thank you for taking the time to read this leaflet.

Appendix 4

Consent Form for Participants in Research Investigation (Clinical Participants)

Consent form for participation in a research investigation

Investigation into the effects of Eye Movements on Memories

(Clinical participants)

The aims and procedures involved in the investigation in which I have been asked to participate have been explained to me by The potential benefits of the research and any potential discomfort or foreseeable risks to myself have been high-lighted. I have also read and understood the participant information leaflet.

I understand that my general practitioner will be informed if I wish to participate in the study, to ensure that there is no medical reason for my not participating in the study.

I have had the opportunity to ask questions and to consider the answers provided.

I understand that participation in the study is voluntary and that I may withdraw from the study at any time of my own accord. Both my general practitioner and other mental health professionals will be informed of my participation in the investigation. I understand that withdrawal will not affect the future care and attention I will receive from my doctors and other health professionals.

I hereby freely give my fully informed consent to taking part in this investigation.

NAME

SIGNATURE

ADDRESS

.....

.....

DATE

I confirm that I have explained the nature of the above investigation to the above named participant

NAME

SIGNATURE

DATE

Appendix 5

Information for General Practitioners

Information for General Practitioners

Dear Dr.....

Re : Research study investigating eye movements and personal memories

I wish to draw your attention that your patient,, has volunteered to participate in a research study investigating eye movements in relation to personal memories. This study has been approved by Warwickshire ethics.

Please find enclosed a copy of the participant information sheet. Your patient has read this information sheet and has met with one of the researchers carrying out the study. Your patient has given written consent to participate in the study and is aware that I am writing to you.

If there is any medical reason why you believe that this patient should not participate in the study please complete the reply slip below. All information will be treated with the strictest confidence. If I do not hear from you in the next four weeks, I shall presume that you have no objection to your patient being involved in the study.

You will be informed as to whether your patient does participate in the study.

Thank you for your help on this matter,

Yours sincerely,

Dr. Kay Garvey, Consultant Clinical Psychologist.

Name of patient _____ D.O.B. _____

Name of G.P. _____

Reason(s) for concern with regards to participation in this study :

signed

Appendix 6

Participant Information Leaflet (Control Group)

Participant Information Leaflet (Control group)

Background

Following a significant trauma, it is common for individuals to suffer from intrusive memories about the trauma. A significant number of individuals go on to develop symptoms of Post Traumatic Stress Disorder (PTSD). A recently developed psychological treatment to alleviate PTSD symptoms uses eye movements as one of its components. Two psychologists (Dr. Kay Garvey and Dr. Gary Willington) working clinically in Warwickshire are interested in finding out what effects eye movements may have on individual memories. Hence, a research programme has been set. There will be two groups of participants in the study. One group will be individuals who are suffering from PTSD and the other group will be a control group who are not suffering from PTSD and have had no contact with mental health services.

Procedure

Each participant will be invited to meet one of the researchers in the study to discuss further the nature of the investigation and to ask any questions you may have about the study. You will be asked for some information about yourself including your age, and whether you have had any contact with the mental health services. If you then wish to participate in the study you will be asked to read and sign a consent form. The study will actually take place at Coventry University and a remuneration fee for inconvenience of £10.00 plus travel expenses will be paid to all participants. The research session will take two to three hours and will occur in either a morning, afternoon or early evening session. Every effort will be made to make participation as pleasant and interesting as possible.

During the investigation.

You will be asked to complete some questionnaires concerning your present emotional and mental well-being. During the course of the investigation, memories of events from your own life (chosen by yourself) will be used in the investigation. All this information will be treated in the strictest confidence and will be coded such that it is anonymous. It will be stored securely at Coventry university.

You will be able to withdraw at any time during the study. If, in the unlikely event that you feel distressed or uncomfortable during the study the researcher will check with you as to whether you wish to continue. There will be no pressure to complete the study.

Still interested ?

If you would like to meet with one of the researchers to discuss the study further, please inform who will pass on your name, address and telephone number to Dr. Kay Garvey. Dr. Garvey will then contact you directly to arrange a convenient appointment to meet you.

Thank you for taking the time to read this leaflet.

Appendix 7

Consent Form for Participants in Research Investigation (Control Participants)

Investigation into the effects of Eye Movements on Memories

(Control group)

The aims and procedures involved in the investigation in which I have been asked to participate have been explained to me by The potential benefits of the research and any potential discomfort or foreseeable risks to myself have been high-lighted. I have also read and understood the participant information leaflet.

I have had the opportunity to ask questions and to consider the answers provided.

I understand that participation in the study is voluntary and that I may withdraw from the study at any time of my own accord.

I hereby freely give my fully informed consent to taking part in this investigation.

NAME

SIGNATURE

ADDRESS

.....

.....

DATE

I confirm that I have explained the nature of the above investigation to the above named participant

NAME

SIGNATURE

DATE

Appendix 8

Sample Letter to Participants outlining examples of stimulus materials required for the experiment

School of Health and Social Sciences

Coventry University

Priory Street Coventry CV1 5FB

Telephone 01203 838328

Fax 01203 838784



C O V E N T R Y
U N I V E R S I T Y

Our ref

Your ref

Date

Dear

I would like to welcome you and to thank you for taking part in this study. I would also like to take this opportunity to introduce myself. My name is Clare Woodward and I am a Clinical Psychologist in Training on the Coventry and Warwick Clinical Psychology Doctorate programme. I will be with you throughout your participation in the study.

I will be contacting you shortly to arrange a suitable place and time to meet. We can pay you £10 for your time as well as travel expenses. I understand that Kay Garvey has already explained to you the details of the study. There will also be an opportunity to ask any additional questions on the day. As you have previously been informed you will need to bring with you some specific materials as detailed next.

You will need to bring six visual images. A visual image can be a photograph, a picture from a newspaper or magazine, a postcard or a poster. You will need three visual images which have a positive or happy connotation for you (they can be of any type and combination) and three visual images which have a negative or sad connotation (again they can be of any type and combination). For example:

A sample list of visual images

Visual images with positive connotations	Visual images with negative connotations
Photograph of 21 st Birthday	Picture of friend who died at age 18 years
Newspaper cutting of England beating Germany in Euro 2000	Magazine picture of the earthquake in Turkey.
Postcard of Cornwall	Newspaper cutting of the Oklahoma bombing when the fireman carries out a small child in his arms.

You will also need to have thought about six auditory recollections. Auditory recollections can include a song, a poem or a story. You will need to have three auditory recollections which have a positive or happy connotation for you (they can be of any type and combination) and three auditory images which have a negative or sad connotation (again they can be of any type and combination). For example:

A sample list of auditory recollections

Auditory recollections with positive connotations	Auditory recollections with negative connotations
"Waterloo" by Abba (song)	"Candle in the wind" by Elton John (song)
"McCavity the Mystery Cat" by T.S. Eliot (poem)	"Don't cry for me Argentina" sung by Madonna (song)
"Football's coming home" by Lightning seeds, Baddiel and Skinner (song)	"Stop all the clocks, cut off the telephone" by W.H. Auden (poem)

Please do not worry if you do not know who wrote the song, poem or story. In addition you do not need to actually bring the song, poem or story with you. All you need is to know roughly the words for a very short period of time. You will not be asked to sing or say the words out-loud but just to sing or say the words to yourself.

Finally, you will need to have thought about six personal recollections. Once again you will need to have three personal recollections with a positive or happy connotation and three personal recollections with a negative or sad connotation. For example:

Sample of personal recollections

Personal recollections with positive connotations	Personal recollections with negative connotations.
"Son's birth"	"Father's funeral"
"Honeymoon in Florida"	"Breaking my leg at aged 15"
"50 th Birthday party"	"Not getting the job I wanted"

Please note that you will be asked to mentally think about the personal recollections for only a very short period of time. In addition please do not worry if you cannot find enough visual images, auditory or personal recollections, as I will help you to select suitable material when we meet. Also please remember to bring with you your glasses if you wear them.

Just to recap, please remember to bring:

- 1) 6 visual images (e.g., photographs, pictures, postcard etc). 3 with positive connotations and 3 with negative connotations.
- 2) A list of 6 auditory recollections (e.g., songs, poems, stories). 3 with positive connotations and 3 with negative connotations.
- 3) A list of 6 personal recollections (e.g., events with emotional associations) 3 with positive connotations and 3 with negative connotations.
- 4) Glasses if appropriate.

I very much look forward to meeting with you soon and I would like to thank you once again for agreeing to participate in the study.

Yours sincerely

Dr Clare Woodward

Appendix 9

Sample copy of the General Health Questionnaire 28

THE

QUESTIONNAIRE

GHQ 28

David Goldberg

Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently

A1 – been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 – been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 – been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 – felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 – been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6 – been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7 – been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1 – lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 – had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 – felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 – been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 – been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 – found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 – been feeling nervous and	Not at all	No more than usual	Rather more than usual	Much more than usual

Appendix 10

Advert for the recruitment of respondents

Help wanted for a study looking at how we make sense of traumatic experiences

Abusive and traumatic experiences can have a fundamental and distressing impact upon our lives. Furthermore it can be very hard to make sense of what has happened and how we feel about ourselves, others and the world in which we live. For some the impact of trauma can be too great and leaves the individual unable to cope and move on in their lives, while for others positive change and personal growth may occur through the process of surviving and coping with traumatic experiences. Of course one could also be left with some areas of one's life going well while other aspects may not be so good. Whatever your experiences I would like to hear from you. I am particularly interested to hear about any *key turning points* (or changes) in your life, which you think have made a difference in terms of how you feel about yourself and the trauma experienced.

The purpose of telling your story is to highlight the variety of experiences that can come from trauma and the many ways that people find to make sense of their experiences. *If you would like to share your story* or find out more about this study I would be very pleased to hear from you. Please write to me at the following address: Dr Clare Woodward (Psychologist in Clinical Training), Coventry University, School of Health and Social Sciences, Priory Street, Coventry, CV1 5FB. To protect anonymity all names and personal identifiers will be removed.

Appendix 11

Information Sheet for Posttraumatic Growth Study

Information Sheet

Who am I? (Brief biographical details)

I have a strong interest in the impact of trauma, which began with my first doctorate at Lancaster University. This research was entitled: *Being Visible: Representations of Self and Identity within Personal Experience Narratives of Childhood Sexual Abuse*. In addition to this I was also involved in research on behalf of the National Commission of Inquiry into the Prevention of Child Abuse. This study was entitled: “*..and do I abuse my children? No!*”: Learning about prevention from people who have experienced childhood abuse’ and was published as part of *Childhood Matters*, Vol 1 & 2, London: HMSO. I am presently working with children and carers in the ‘looked after system’ before moving to the Women’s Service at Rampton Special Hospital. Finally, I have been involved with the charity NAPAC (The National Association for People Abused In Childhood) since January 1997.

Why this study?

This study forms part of my clinical training as well as building upon my earlier research. I am particularly interested in how people make sense of traumatic experiences and am keen to explore aspects of personal growth and positive change. Much of the work on trauma has focused on the negative impact that such experiences bring. With this in mind I am keen to highlight the many strengths that can emerge when faced with adversity as well as explore areas such as resilience, thriving and creativity. I also have a strong interest in the therapeutic use of story telling.

What I need

- A personal narrative in the form of a letter/story outlining your own experiences. These stories can be as long or short as you would like to make them. I have included a guidance sheet to help you start the story should you require it: however, I am keen to emphasise that this is your story to be told anyway you wish to tell it. There is no right or wrong way and whatever you choose to write will be of benefit to the study.
- In addition to your story, I require some additional information from yourself. This additional information comprises:
 - Brief demographic information such as age etc
 - A very brief sheet giving you the opportunity to say how you felt writing the letter¹
 - Four questionnaires looking at general well being².

My promises to you.

- To ensure that your anonymity and confidentiality is protected
- To keep safe all letters and information received
- To send you the results and conclusion of the study

¹ Data collected from respondents’ impressions of writing the narratives will be disseminated as a separate paper.

² Similarly the questionnaire data is also to be written up as a separate paper.

Appendix 12

Brief Background Information Sheet for Respondents

Brief Background Information Sheet (please circle or write)

Sex:	FEMALE	MALE
Ethnicity (please write)		
Age: (please write)		
Qualifications	GCSE/O Levels University undergraduate Degree Other (please write) _____	A Levels or equivalent Postgraduate Degree
Marital Status	Single Divorced	Living with Partner Widowed Married
Occupation (please write if applicable)		
Religion (please write if applicable)		

Appendix 13

Clinical Psychology Review – Instructions to Authors

INSTRUCTIONS TO AUTHORS

AIMS AND SCOPE: *Clinical Psychology Review* publishes substantive reviews of topics germane to clinical psychology. Its purpose is to help clinical psychologists keep up-to-date on relevant issues outside of their immediate areas of expertise by publishing scholarly but readable reviews. Papers cover diverse issues, including: psychopathology, psychotherapy, behavior therapy, behavioral medicine, community mental health, assessment, and child development.

Reviews on other topics, such as psychophysiology, learning therapy, and social psychology, often appear if they have a clear relationship to research or practice in clinical psychology. Integrative literature reviews and summary reports on innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies are not appropriate.

SUBMISSION REQUIREMENTS: All manuscripts should be submitted to Alan S. Bellack, Department of Psychiatry, The University of Maryland at Baltimore, School of Medicine, 685 West Baltimore Street, Suite 618, Baltimore, MD 21201-1549, USA. Submit three (3) high-quality copies of the entire manuscript; the original is not required. Allow ample margins and type double-space throughout. Papers should not exceed 50 pages (including references). One of the paper's authors should enclose a letter to the Editor, requesting review and possible publication; the letter must also state that the manuscript has not been previously published and has not been submitted elsewhere. One author's address (as well as any upcoming address change), telephone and FAX numbers, and E-mail address (if available) should be included; this individual will receive all correspondence from the Editor and Publisher.

Papers accepted for *Clinical Psychology Review* may not be published elsewhere in any language without written permission from the author(s) and publishers. Upon acceptance for publication, the author(s) must complete a Transfer of Copyright Agreement form.

COMPUTER DISKS: Authors are encouraged to submit a 3.5" HD/DD computer disk to the editorial office; 5.25" HD/DD disks are acceptable if 3.5" disks are unavailable. Please observe the following criteria: (1) Send only hard copy when first submitting your paper. (2) When your paper has been refereed, revised if necessary, and accepted, send a disk containing the final version with the final hard copy. Make sure that the disk and the hardcopy match exactly (otherwise the diskette version will prevail). (3) Specify what software was used, including which release, e.g., WordPerfect 6.0a. (4) Specify what computer was used (IBM compatible PC, Apple Macintosh, etc.). (5) The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available. (6) The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to Contributors. (7) The file should be single-spaced and should use the wrap-around end-of-line feature, i.e., returns at the end of paragraphs only. Place two returns after every element such as title, heading, paragraphs, figure and table call-outs. (8) Keep a back-up disk for reference and safety.

TITLE PAGE: The title page should list (1) the article; (2) the authors' names and affiliations at the time the work was conducted; (3) a concise running title; and (4) an unnumbered footnote giving an address for reprint requests and acknowledgments.

ABSTRACT: An abstract should be submitted that does not exceed 200 words in length. This should be typed on a separate page following the title page.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the *Publication Manual of the American Psychological Association*, 4th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Avoid abbreviations of journal titles and incomplete information.

Reference Style for Journals:

Raymond, M. J. (1964). The treatment of addiction by aversion conditioning with apomorphine. *Behavior Research and Therapy*, 3, 287-290.

For Books:

Barlow, D. H., Hayes, S. C., & Nelson, R. O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings*. Elmsford, NY: Pergamon.

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Appendix 14

British Journal of Clinical Psychology – Instructions to Authors

NOTES TO CONTRIBUTORS

1. The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical and health psychology. Topics covered reflect the broad role of clinical and health psychologists and include descriptive studies as well as studies of the aetiology, assessment and amelioration of disorders of all kinds, in all settings and amongst all age groups. Empirical investigations from any theoretical perspective of the relation of intrapersonal and interpersonal processes to disorder are welcome, as are studies of the delivery of health care in hospital or community settings. Relevant populations include people with psychiatric and neuropsychological disorders, and people with learning difficulties. Studies with samples not currently experiencing any disorder may be considered if they bear directly on clinical theory or practice.

A separate Health Psychology Section of the Journal has now been created in recognition of the growing importance of the applications of psychology outside the traditional psychiatric domain. Submissions are encouraged of clinical and experimental research on the development and management of medical conditions. Empirical research into psychosocial responses to illness, and the behaviours that put health at risk, is also welcome.

2. The following types of paper are invited:

- (a) Papers reporting original empirical investigations.
- (b) Theoretical papers, provided that these are sufficiently related to empirical data
- (c) Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications.
- (d) Brief Reports and Comments (see paragraph 6).

Case studies are normally published only as Brief Reports. Papers are evaluated in terms of their theoretical importance, contributions to knowledge, relevance to the concerns of practising clinical psychologists, and readability. Papers generally appear in order of acceptance, except for the priority given to Brief Reports and Comments.

3. The circulation of the Journal is worldwide, and papers are reviewed by colleagues in many countries. There is no restriction to British authors, and papers are invited from authors throughout the world.

4. The Code of Conduct of The British Psychological Society requires psychologists 'Not to allow their professional responsibilities or standards of practice to be diminished by considerations of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors'. The racism of apartheid is incompatible with the Society's Code and the Society therefore condemns apartheid and resolves to avoid all links with psychologists and psychological organizations and their formal representatives that do not affirm and adhere to the principles in the clause of its Code of Conduct. In cases of doubt the Journals Office asks authors to sign a document confirming their adherence to these principles.

5. Papers should be prepared in accordance with The British Psychological Society's *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, England. Contributions should be kept as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A summary of up to 200 words should be provided, but a shorter abstract with shorter papers. The title should indicate exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing systems.

- (a) Contributions should be typed in double spacing with wide margins and only on one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.
- (b) The Journal operates blind review; authors are required to eliminate clues to their identity. Information revealing authorship (such as authors' names and institutional affiliations, and personal acknowledgments) must be confined to removable front page, and the text must be free of such clues as identifiable self-citations ('In our earlier work...') and the names of localities or institutions. The paper's title should appear at the top of the first page of text.
- (c) Tables should be typed in double spacing on separate sheets. Each should have a self-explanatory title and should be comprehensible without reference to the text. They should be

referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

- (d) Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets numbered sequentially 'Fig. 1', etc., and each identified on the back with the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size. Special care is needed with symbols: correction at proof stage may not be possible. Lettering must not be put on the original drawing but upon a copy to guide the printer. Captions should be listed on a separate sheet.

- (e) Bibliographical references in the text should quote the author name and the date of the publication thus; Hunt (1993). They should be listed alphabetically by author at the end of the article according to the following format:

Moore, R. G. & Blackburn, I.-M. (1993). Sociotropy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, 32, 460-462.

Stephens, A. & Wardle, J. Cognitive predictors of health behaviour in contrasting regions of Europe. In C. R. Brewin, A. Stephens & J. Wardle (Eds), *European Perspectives in Clinical and Health Psychology*, pp. 101-118. Leicester: The British Psychological Society.

Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

- (f) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see *BPS Style Guide*).
- (g) Authors are required to avoid the use of sexist language.
- (h) Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, full details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

6. Brief Reports and Comments are limited to two printed pages. These are subject to an accelerated review process to afford rapid publication of research studies, and theoretical, critical or review comments whose essential contribution can be made within a small space. They also include research studies whose importance or breadth of interest is insufficient to warrant publication as full articles, and case reports making a distinctive contribution to theory or method. Authors are encouraged to append an extended report to assist in the evaluation of the submission and to be made available to interested readers on request to the author. To ensure that the two-page limit is not exceeded, set typewriter margins to 66 characters maximum per line and limit the text, including references and a 100 word abstract, to 150 lines. Figures and tables should be avoided. Title, author name and address for reprints and data of receipt are not included in the allowance. However deduct three lines from the text each and every time any of the following occur:

- (a) title longer than 70 characters,
- (b) author names longer than 70 characters,
- (c) each address after the first address,
- (d) each text heading (these should normally be avoided).

A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side of a mathematical operator.

7. Proofs are sent to authors for correction of print, but not for introduction of new or different material. They should be returned to the Journals Manager as soon as possible. Fifty complimentary copies of each paper are supplied to the senior author on request; further copies may be ordered on a form supplied with the proofs.

8. Submission of a paper implies that it has not been published elsewhere and is not currently under consideration for publication elsewhere. Authors are responsible for getting written permission to publish lengthy quotations, illustrations etc., of which they do not own copyright.

9. The tendency is growing for articles to be reproduced abroad without permission. To protect the interests of authors and journals the BPS requires copyright to be assigned to the Society (by signing a form), on the express condition that authors may use their own material elsewhere at any time without permission.

Appendix 15

The Journal of Counseling Psychology – Instructions to Authors

tions, consultation, supervision, training, prevention, and psychological education), (b) career development, (c) diversity and underrepresented populations in relation to counseling activities, (d) the development of new measures to be used in counseling activities, and (e) professional issues in counseling psychology. In addition, the *Journal of Counseling Psychology* considers reviews or theoretical contributions that have the potential for stimulating further research in counseling psychology, and conceptual or empirical contributions about methodological issues in counseling psychology research. The *Journal of Counseling Psychology* considers manuscripts that deal with clients who are not severely disturbed, who have problems with living, who are experiencing developmental crises, or with the strengths or healthy aspects of more severely disturbed clients. Both quantitative and qualitative methods are appropriate. Replications and extensions of previous studies are encouraged.

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Appendix 16

Counselling – Information for Contributors

The Association aims to:

- promote the understanding and awareness of counselling throughout society;
- increase the availability of trained and supervised counsellors;
- maintain and raise standards of training and practice;
- provide support for counsellors and those using counselling skills and opportunities for their continual professional development;
- respond to requests for information and advice on matters relating to counselling;
- represent counselling at national and international levels.

Towards these ends, the Association brings together the commitment and resources of a wide range of people, through individual and organisational membership.

The Association

- produces publications about counselling;
- maintains a film and video library about counselling;
- publishes the quarterly journal *Counselling*;
- has developed Codes of Ethics and Practice for Counsellors, Counselling Skills, Trainers, and for the Supervision of Counsellors;
- operates an accreditation scheme for individual counsellors, trainers and supervisors, and for counsellor training courses.
- runs an information office and publishes directories describing counselling services and training in counselling;
- is developing a network of local affiliated groups.

Members may join one or more of the Divisions, representing specific fields of work:

Association for Counselling at Work	(ACW)
Association for Pastoral Care and Counselling	(APCC)
Association for University and College Counselling	(AUCC)
Counselling in Education	(CIE)
Counselling in Medical Settings	(CMS)
Personal, Relationship and Groupwork	(PRG)
Race and Cultural Education in Counselling	(RACE)

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Information for Contributors

General

The Editors reserve the right to edit and revise all contributions.

Use non-gender-specific language; please avoid using masculine pronouns to refer to people in general.

Photographs should be monochrome, and all illustrations, diagrams, etc., must be presented camera-ready (or on disk in EPS or TIFF format). Low quality artwork will not be used. Colour illustrations may be considered, but the author will be asked to pay the costs of reproduction.

All items are to be addressed to the appropriate Editor and sent to *Counselling*, BAC, 1 Regent Place, Rugby, Warwickshire CV21 2PJ.

Articles

The Editor welcomes research findings; counselling practice demonstrated through descriptions of case studies or group sessions, etc.; theoretical studies; considered responses to published articles or current issues; reports of experiments.

Please send three copies plus a large s.a.e. to Judith Longman, Managing Editor.

Manuscripts must be typed, double-spaced throughout (including references, quotes, tables, etc.) with 2.5 cm margins. Please include an overall word count. Provide headings and sub-headings where appropriate. No article may exceed 4,000 words without the prior agreement of the Editor.

If material also exists in electronic form (i.e. word-processing disks), the BAC can make use of it to reduce typesetting costs, but the availability or not of a disk makes no difference to the acceptability of material (useable formats: Word, WordPerfect or ASCII on 3.5 in. disks, PC or Mac). Three hard copies are required even if a disk is also sent.

On a separate piece of paper, include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has been submitted only to *Counselling*. The rest of the manuscript must be free of information which might identify the author, since academic articles are subject to anonymous review.

Where case studies are included, the author should sign a statement on a separate sheet of paper confirming that permission for inclusion has been

obtained from any client described in the article. The inclusion of case studies should be justified by the need to demonstrate something or to make a point, and care must be taken to disguise the client.

Authors of articles accepted for publication will be sent a form on which to agree to copyright being transferred to BAC. Permission to include copyright material from other sources must be obtained by the author and acknowledged in the article.

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Letters for publication should be sent to the Managing Editor.

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The News Editor welcomes news, views and ideas; reports from affiliated groups, Divisions or Committees of the Association; information about new publications, organisations or activities; details regarding exchange research needs, and training; obituaries – indeed any item which will be of interest to *Counselling's* readership. *The Voice of Counselling* is devoted specifically to BAC activities and concerns. Items for inclusion should be sent to the Information and Publications Manager.

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Advertising Deadlines: November, 4.9.98; February 1999, 4.12.98; May, 5.3.99; August, 4.6.99

November, 28.8.98; February 1999, 27.11.98; May, 26.2.99; August, 28.5.99